AVENT, JANEÉ R., Ph.D. What Then Shall We Say to These Things? An Investigation of African American Pastors' Response to Mental Health Needs in the Black Church and Their Influence on African American Help-seeking Behaviors and Coping Strategies. (2013)
Directed by Dr. Craig S. Cashwell. 259 pp.

African Americans are often disproportionately represented in vulnerable populations that could likely cause them to be at a greater risk for struggling with anxiety and depression (U.S. Department of Health and Human Services, 2001), however, they tend to seek professional counseling at a much lower rate than other racial and ethnic populations and instead turn their spiritual leaders as a resource (Ayalon & Young, 2005). Because of under-utilization of mental health services within the African-American community (Avalon & Young, 2005), more research attention should be directed toward factors that affect the help-seeking behaviors of African Americans (U.S. Department of Health and Human Services, 2001).

Generally, the Black Church is considered a less stigmatized method of getting help in the Black community (Andrews, Stefurak, & Mehta, 2010), a solution for many mental health problems (Newhill & Harris, 2007) and pastors are valued as credible sources for assistance with social and psychological problems because of their status as pastor, often regardless of the pastor's educational background, knowledge of mental health issues, and previous experience (Kane & Greene, 2009). There remains much that is unknown about pastoral motivations, beliefs, attitudes, and influence related to mental health needs of their parishioners. Therefore, the purpose of this study was to investigate the pastors' response to parishioners dealing with anxiety, depression, unemployment, bereavement, and familial concerns; their motivations to encourage or discourage help-

seeking outside of the Black Church; their perspectives on secular counseling services in their community; their perspective on spiritual, biological, psychological, and social coping methods; and their beliefs about identifying and responding to maladaptive religious coping strategies.

Consensual Qualitative Research was used as the research protocol to collect and analyze the data. Findings from this study suggest that African Americans frequently seek help from their pastors regarding anxiety, depression, bereavement, unemployment, and relationship issues. Further, results from this study also suggest that African American pastors attribute anxiety and depression to social and spiritual spheres of influence and endorse spiritual, social, and integrative coping strategies. Moreover, African American pastors seem to differentiate between adaptive and maladaptive forms of religious coping.

WHAT THEN SHALL WE SAY TO THESE THINGS? AN INVESTIGATION OF AFRICAN AMERICAN PASTORS' RESPONSE TO MENTAL HEALTH NEEDS IN THE BLACK CHURCH AND THEIR INFLUENCE ON AFRICAN AMERICAN HELP-SEEKING BEHAVIORS AND COPING STRATEGIES

by

Janeé R. Avent

A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro
2013

Approved by

Dr. Craig S. Cashwell
Committee Chair

Dedicated to my grandmother, Arnetta Sessoms Avent. I never got the opportunity to meet you and all of my life I've wondered what you looked like, I've wondered about the smell of your clothes, but most of all I wondered about the sound of your voice. Well on the days when I was exhausted, overwhelmed, and wanted to give up I heard a quiet, "You can do it". Somehow I knew it was you and I knew that I had finally heard your voice. I hope that I have made you proud.

"What then shall we say to these things? If God is for us, who can be against us"
~ Romans 8: 31, New Kings James Bible~

APPROVAL PAGE

This dissertation, written by Janeé R. Avent, has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair Dr. Craig S. Cashwell

Committee Members Dr. José Villalba

Dr. Shelly Brown-Jeffy

Dr. Terry Ackerman

March 25, 2013
Date of Acceptance by Committee

March 25, 2013
Date of Final Oral Examination

ACKNOWLEDGMENTS

Lord, thank You for the grace to complete this part of the journey and to face the journey ahead. It is my prayer that in all that I do, You will get all the glory!

Mommy and Daddy, thank you for letting me dream and supporting me every step of the way. You all are my strength and your unconditional love has carried me through every challenge and triumph of life.

Montrille, thank you for holding my hand and my heart through this journey. Thank you for showing me love, the 1 Corinthians 13 kind of love.

MJ, there is no one that I fight harder with ☺ but who I fight harder for than you. You are not only my brother, but you were my very first friend. I love you to life!

"The Avents" and "The Battles," I am grateful to be able to call you family and I share this accomplishment with all of you.

Aunt Barbara, Aunt "Boot," and Uncle Stoney, thank you for how you continue to pour into my life. Whether it was the prayers that you prayed, the meals that you cooked, or the "lunch money" you sent ☺, it was such a crucial part of my journey.

Aunt Pam, you've taught me the meaning of being selfless, how to be dependable, and how to be a best friend and godmother. MJ and I are so blessed to have you.

My Word Tab Family, growing up I always wanted an older brother or sister. Well, God must have heard my prayers because he gave me all of you.

My friends, I am so appreciative that I have gotten to grow up and share life with you all. Wherever life takes us, we will forever share an "unbreakable" bond as "the greatest young people in America."

My cohort, there are probably no words to describe what you all mean to me. We came in as peers, we became friends, but we leave as family. I can't wait to see how each of you will make such a difference in the world. *Lucy,* the days were long but the laughs and memories we have from our days at Panera will be with me always.

My committee, Dr. Cashwell, thank you for being my mentor and "second father". You have supported me, prayed for me, challenged me, laughed with me, and let me cry whenever I needed. I am forever grateful and promise to pay it forward. Dr. Shelly, you have such a genuine spirit and are such a great role model. Thank you for believing in me, encouraging me, and sacrificing so much of your time to make this dissertation possible. Dr. Villalba, you are one of the most intelligent people I know. Thank you for sharing your gift with me. Dr. Ackerman, thank you for going above and beyond and serving on my committee. I am forever grateful.

Metoka, thank you for introducing me to CQR and for serving as auditor on this project.

Pastor James D. Gailliard, thank you for your insight through this process and for fearlessly and unapologetically living out the prophetic voice.

Association for Counselor Education and Supervision and *Southern Association for Counselor Education and Supervision,* thank you for your support of this dissertation.

The participants, thank you for your sacrifice of time and your contribution to this dissertation and the many lives you touch through ministry.

My guardian angels, Luther Avent, Geneva Battle, Rev. Ernest Battle, Sr., and Brenda Lee Battle you all are in my hearts forever. I love you and thank you for watching over me.

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CHAPTER I

INTRODUCTION

> Without counsel purposes are disappointed: but in the multitude of counselors they are established. (Proverbs 15:22, King James Version Bible)

Introduction

Researchers have found that African Americans' mental health is greatly affected by the social and physical health issues that plague the community (U.S. Department of Health and Human Services, 2001). Further, African Americans are at higher risk for life-threatening physical health complications such as diabetes (American Diabetes Association, 2012), heart disease (U.S. Department of Health and Human Services, 2010), prostate cancer (U.S. Department of Health and Human Services, 2012), HIV/AIDS (U.S. Department of Health and Human Services, 2010), and breast cancer (U.S. Department of Health and Human Services, 2012). This is further complicated by other risk factors that are high in the African American community, such as homelessness (National Coalition for the Homeless, 2009), low socioeconomic status (U.S. Department of Health and Human Services, 2010), incarceration (Liptak, 2008), and substance abuse (U.S. Department of Health and Human Services, 2001). Accordingly, more careful attention should be directed toward the mental health issues, help-seeking behaviors, and various counseling services used by African Americans (U.S. Department of Health and Human Services, 2001). For clarification purposes, it is important to note that the terms

African American and *Black* will be used interchangeably throughout this study to reference the same group of people.

Overall, mental illness rates among African Americans appear to be comparable with other racial and ethnic groups (U.S. Department of Health and Human Services, 2001). This is difficult to measure, however, as Blacks are overrepresented in vulnerable populations, often dually diagnosed, and tend to withhold symptoms from care providers (U.S. Department of Health and Human Services, 2011). Further, African Americans' distrust of researchers has contributed to the limited knowledge on the prevalence of mental illness within the African American community. When asked, African Americans themselves have identified familial issues, anger management concerns, the mental health of children and adolescents in their community, issues with incarceration, and substance abuse as mental health problems in their communities that need attention, service, and resolution (Newhill & Harris, 2007).

Two mental health issues within the Black community, anxiety and depression, have been extensively studied. Depression is a mental illness that is classified as a mood disorder in the Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association, 2000) that does not discriminate against any group of people, affecting multitudes of various demographic sects (World Health Organization, 2012). Approximately 7% of the general population in the United States is diagnosed with depression (The Substance Abuse and Mental Health Administration, 2009) with countless others likely being either undiagnosed or struggling with subclinical levels of depression. African Americans may be at an increased risk for depression as researchers

have found that negative life events such as exposure to violence and illness, both prevalent in the African American community, correspond with an increased risk for depression (Mitchell & Ronzio, 2011). While approximately 121 million people all over the world have been affected by depression, only about 25% of these people have access to appropriate treatment (World Health Organization, 2012), with African Americans being among one of the groups least likely to receive counseling (González, Tarraf, Whitfield, & Vega, 2010).

Similarly, anxiety affects nearly 18-21% of the U.S. population (Anxiety and Depression Association of America, 2012; Latzman, 2011). Similar to depression, these numbers likely underestimate the prevalence of anxiety because anxiety often is undiagnosed (Gwynn et al., 2008) and prevalence data fails to account for those struggling with subclinical levels of anxiety. Although the overall prevalence rates for anxiety are lower for African Americans when compared to other racial and ethnic groups, anxiety remains problematic because African Americans who do experience anxiety tend to experience a level of anxiety that is more debilitating when compared to Whites, often causing them to be unable to fulfill responsibilities of their normal routine (Himle, Baser, Taylor, Campbell, & Jackson, 2009). Further, anxiety and depression rates are higher among individuals who are unemployed and have public rather than private health care insurance (Gwynn et al., 2008). This is relevant to the Black community because African Americans have higher unemployment rates than the general population (16.6% vs. 8.2%; Bureau of Labor Statistics, 2012) and 21% of African

Americans receive, a public, government funded insurance option Medicaid (U.S. Department of Health and Human Services, 2011).

There are many reasons why people, in this case African Americans, could be experiencing anxiety and depression. Some of these reasons could include issues with bereavement, family, and high rates of unemployment and economic disadvantage. Although grief is an experience that is common to all groups of people regardless of race, gender, religion, and other distinguishing demographic variables (Laurie & Neimeyer, 2008), the bereavement process seems to affect racial groups differently (Fitzpatrick & Tran, 2002). Minority racial groups, such as African Americans, tend to have unique emotional responses, rituals, and familial roles that make their bereavement process distinct from other cultures (Schoulte, 2011). When compared to Caucasians, for example, African Americans appear to have lower rates of depression connected to bereavement. This could indicate that they are receiving support from alternative sources and that they make meaning of death differently (Fitzpatrick & Tran, 2002). Death is experienced more frequently in the African American community (Laurie & Neimeyer, 2008), largely due to social issues previously stated, including shorter life span, increased physical illness, and homicide rates. Researchers have suggested that further investigation should address the types of support African Americans receive during the grief process (Fitzpatrick & Tran, 2002).

Additionally, family issues appear to affect African Americans. For instance, it is important to consider the influence of ethnicity, culture, and socioeconomic status on the institutions of family and marriage. For example, it is probable that marriage is not only

influenced by one's socioeconomic status but vice versa as well as the stressors associated with financial strain can negatively impact marital quality of life (Bryant, Taylor, Lincoln, Chatters, & Jackson, 2008). Similarly, race and ethnicity appear to influence parenting. Values common in the African American community and often distinguishing of their culture may affect parenting styles and outcomes of children behavior. For example, increased communication between family members decreases the likelihood of children's conduct problems and African Americans are less likely to be as communicative as other populations (N. Hill & Bush, 2012).

One of the challenges researchers face in determining accurate mental health prevalence data for African Americans is the disparity in the rates of formal help-seeking behaviors that exist between African Americans and other racial and ethnic groups (Buser, 2009). Compared to majority racial and ethnic groups, minority populations and, for the purpose of this study, specifically African Americans are less likely to seek mental health help from counseling professionals (Ayalon & Young, 2005; Gallo, Ford, & Anthony, 1995). Clearly, race is an important factor in understanding the disparities in help-seeking behaviors. In fact, race has been found to be a better predictor of help seeking behaviors than either finances or education level (Youman, Drapalski, Steuwig, Bagley, & Tangney, 2010). Researchers have found that only 15.7% of all African American persons diagnosed with a mood disorder of any type sought help from a mental health specialist, and the numbers are even lower for anxiety disorders, with only 12.6% of African Americans diagnosed with anxiety disorders seeking mental health services (U.S. Department of Health and Human Services, 2001). The disparities in rates of help

seeking extend to African American adolescents as well, as they are less likely than their peers from other racial and ethnic backgrounds to seek help for mental health issues (Broman, 2012).

Scholars and researchers have identified and discussed a number of barriers to help-seeking behavior. Some of these barriers include stigma, shame, a concern for the reaction of family and friends (Awosan, Sandberg, & Hall, 2011), denial of symptomology, an external locus of control regarding their health (Andrews, Stefurak, & Mehta, 2010; Ayalon & Young, 2005), preference for a Black counselor (Awosan et al., 2011; Townes, Chavez-Korrell, & Cunningham, 2009), alternative beliefs about the etiology of mental health issues (Farris, 2006), cultural norms in the Black community (Awosan et al., 2011), institutional racism, and cultural mistrust and paranoia (Townes et al., 2009). These barriers may be even more prevalent for African Americans living in rural areas (Murry, Heflinger, Suiter, & Brody, 2011), which is troubling as most Blacks reside in rural areas of the southern United States (U.S. Department of Health and Human Services, 2011). African Americans appear to be concerned about having to work with White counselors (Awosan et al., 2011) and tend to prefer an African American counselor because of distrust in traditionally White institutions like the mental health system. In this regard, however, African Americans are faced with a dilemma, as the pool of African American counselors is scarce. In this light, African Americans often seek alternative resources (Townes et al., 2009).

One alternative resource that is central within the African American community is the Black Church. Generally, the church is considered a less stigmatized method of

getting help in the Black community (Andrews et al., 2010) and a solution for many mental health problems (Newhill & Harris, 2007). Rather than seek help from secular resources like counseling professionals, African Americans tend to rely more on their spiritual leaders for counseling services when faced with difficult life situations and, in general, are more likely to go to their spiritual leaders than mental health professionals and medical doctors (Chatters et al., 2011).

There is substantial empirical evidence that one's religious life is a critical feature of the developmental process and can serve to improve one's overall well-being (Wiggins, 2011). There are positive benefits to incorporating spirituality and faith in one's life, including greater physical (Matthews et al., 1998) and psychological (Jourbert, 2010) health. Specifically within the African American community, researchers have found religion and spirituality to be protective factors against anxiety and depression (Mitchell & Ronzio, 2011) and grief (Laurie & Neimeyer, 2008; S. H. Smith, 2002). Accordingly, researchers have suggested that future research focus more in-depth on African American spirituality and religion (Mitchell & Ronzio, 2011).

At the same time, the possibility exists that an over-reliance on religious community, also referenced as maladaptive religious coping, to the exclusion of other resources, may be problematic. The maladaptive perspective is specifically relevant to religions such as Christianity that tend to promote suffering as a rite of passage to augment character and enhance strength (Exline, 2002). Furthermore, Marks (2005) suggested that just as faith communities can serve as sources of stress relief, they also have the potential to cause increased stress. For example, it is not uncommon for grieving

family members to be "encouraged" to not be sad because their family member has gone to "a better place." While this may be theologically consistent with the individual's beliefs, it fails to affirm the emotional and psychological realities of dealing with loss. In an effort to repress the sadness, the individual may, in fact, complicate the grieving process by suppressing normal emotional, physical, and psychological processes associated with grieving. When this occurs, the spiritual is not integrated with the biological, psychological, and social realms.

One framework for holistic care of clients is the bio-psycho-social-spiritual model. Dr. George Engel (1978) pioneered the bio-psycho-social model as an alternative and somewhat visceral response to traditional medical models being used by most health care providers. Patients had become dissatisfied with the treatment they were receiving from their physicians and often left appointments feeling frustrated, unheard, misunderstood, and still in pain (Engel, 1978). Engel argued that understanding the person with the illness (i.e., the psychosocial aspects) is much different and perhaps more complicated than solely understanding and treating the illness in isolation.

Perhaps one of the most notable limitations of the original bio-psycho-social model was the exclusion of spirituality. To address this limitation, Puchalski and Romer (2000) suggested that when assessing clients, questions about their spiritual and religious lives could provide information about how they make meaning in life, which could actually be influencing the presentation of their current condition. In fact, some scholars have noted that spirituality seems to be what connects the biological, social, and psychological (Zittel, Lawrence, & Wodarski, 2002). To the extent this is true, the

exclusion of spirituality leaves the model, and subsequently the understanding of the client, incomplete (Cohen & Koenig, 2003; Zittel et al., 2002). Thus, the Bio-Psycho-Social-Spiritual Model emerged as a culturally sensitive theoretical framework that allowed for a client to be holistically assessed from a biological, psychological, social, and spiritual perspective. It is a comprehensive assessment method that considers a client at the "cellular, tissue, organismic, interpersonal and environmental levels" (Fava & Sonino, 2008, p. 1). For these reasons, this model serves as the organizing theoretical framework and foundation for the current study. With the addition of the spirituality component to the traditional Bio-Psycho-Social model, the religious coping strategies of many African American clients are considered, addressed, and appreciated (Clark, Anderson, Clark, & Williams, 1999).

Religion and spirituality are important in the lives of many clients from various backgrounds, certainly not only those of African descent (J. S. Young & Cashwell, 2011). Often, spirituality and religion are used synonymously but they have been distinctly defined in the literature. Additionally, they often have very different connotations. Spirituality is typically considered a more internal personal journey to find meaning in life while religion is considered a more organized, communal approach to meaning making imbedded with particular doctrines and directions for living (Cashwell & Young, 2011; Janis, 2000) that often provide a structure for spirituality (Cashwell & Young, 2011). Although scholars have distinguished between spirituality and religion, the majority of people do not differentiate between the two and note having both (Koenig, George, & Titus, 2004; Zinnbauer, Pargament, & Cowell, 1997) with a significant

amount of overlap between the two (J. S. Young & Cashwell, 2011). In fact, for many, the two are "inextricably intertwined" (C. S. Cashwell, personal communication, June 11, 2012) with one supporting the other and with an individual valuing both as important aspects of their identity and approach to life (Cashwell & Young, 2011).

Because of historical context, religion and spirituality are highly salient within the African American community and must be included in the discussion of the African American experience (Hoffman, Hoffman, Hoffman, & Cleare-Hoffman, 2010). Religion, with a concentration on Christianity, has been an important resource and coping method for African Americans dating back to slavery (Wilmore, 2006). Nearly 80% of African Americans identify religion as an important part of their lives and 50% attend church at least weekly, and a strong majority of these practice within the Christian tradition (Pew Forum on Religion and Public life, 2009). Through religion, African Americans were able to liken their suffering and oppression to biblical stories like the enslavement of the Israelites (G. C. Smith, 1988) and the persecution and ultimate crucifixion of Jesus (Terrell, 1998), allowing them to make meaning of their often tumultuous life experiences in the United States (Long, 1997; G. C. Smith, 1988).

A central component to the religious lives of African Americans is the Black Church, with 59% of African Americans reporting a religious affiliation within the Black Church (Pew Forum on Religion and Public Life, 2009). The Black Church is defined as a Protestant "multitudinous community of churches, which are diversified by origin, denomination, doctrine, worshipping culture, spiritual expression, class, size, and other less obvious factors" (Douglass & Hopson, 2001, p.96). Described as a "total" (S.

Brown-Jeffy, personal communication, April 2, 2012) and "primary" (J. D. Roberts, 1994) institution, the Black Church has been the place where the public and private lives of Blacks intersect (Pinn, 2010), an atmosphere for therapeutic change (Gilkes, 1980), a gateway into the lives of many Black Americans (Watson et al., 2003), and a reflection of the Black community as a whole (Douglas & Hopson, 2001). The roles and responsibilities of the Black Church are varied and extend beyond meeting the spiritual needs of its members, as the Black Church is challenged to be spiritually vibrant while remaining socially relevant (Billingsley, 1999). Noted characteristics making the Black Church unique from other religious institutions include the particular theologies that guide the operation of the church, the integral role of the pastor, the unique styles of call and response preaching, gospel music, and the emotional expressions of the people during worship services as evidence of the presence of the Holy Spirit (C. E. Lincoln & Mamiya, 1990; Moore, 2003). Fully understanding the Black Church requires understanding the historical context through which it developed, was shaped, and continues to operate.

The Black Church was formed during the era of slavery when Blacks were forbidden from preaching and congregating together (Johnson, 1954). Even after the abolition of slavery, racism created an environment that made it necessary for African Americans to form a separate church apart from the predominately White churches (C. E. Lincoln, 1973). After the dissolution of the African American family due to the ills of slavery, the Black Church was charged with its restoration (Frazier, 1963). During times of oppression, the Black Church became a safe haven and a refuge for many (Wilmore,

2006), providing African Americans with a sense of power when they felt helpless and their conditions appeared to be hopeless (G. C. Smith, 1988). The influence of the Black Church extends to the education, politics (Johnson, 1954), culture, and racial identity of African Americans (Zuckerman, Barnes, & Cady, 2003). Further, the Black Church has worked hard to remain active and improve the plight of African Americans. The majority of African Americans believe that the Black Church has improved their condition (Taylor, Thornton, & Chatters, 1987) and has served as a catalyst to move the African American community in a more positive direction (Wilmore, 2006). One of the pillars of the Black Church has been and continues to be the men and women who serve in leadership positions, affectionately referred to by many as Pastor (C. E. Lincoln & Mamiya, 1990).

Like the Black Church, pastors also have great power and influence on the social lives, economic vitality, and physical and mental health of their congregation members (J. D. Roberts, 1994; Wimberley, 1991). In much of the literature, the terms *clergy*, *minister*, and *pastor* are used interchangeably to reference spiritual leaders in the Black Church (Billingsley, 1999). In the current study, the term *pastor* will be used to refer to the primary spiritual leaders of local congregations of the Black Church. If the Black Church operates as a catalyst for change, then it is the pastors who are often at the forefront of these efforts (J. D. Roberts, 1994). While some of the authority and responsibility of pastors, like delivering the sermon, is explicitly stated in ordination charges, much of pastors' authority and responsibility remains unwritten and implied (Carroll, 1981).

Just as understanding the Black Church requires contextual considerations, so too does the understanding of the pastor as an integral figure in the spiritual and secular lives of African Americans. After slavery nearly destroyed the African American family, the church assumed the role of restoring the familial institution, acting as a surrogate family for many, and often placing the pastor as the parental figure (Erskine, 1991). When African Americans were enslaved, pastors instilled hope by communicating information about heaven, a world with promises of freedom and reward (Wilmore, 2006). During the civil rights era, influential civic leaders such as Martin Luther King, Jr. were also pastors in the Black Church (Erskine, 1991). During that era, many pastors were active in organizations such as the National Association for the Advancement for Colored People (NAACP) and held political office when allowed to do so (Billingsley, 1999).

The characteristics of the pastor appear to make a difference in the involvement of the church in the community. For example, younger pastors and those with more education tend to engage more with the local community (Billingsley, 1999), which could include mental health services for members. The pastoral influence extends beyond the collective experiences of African Americans, which include the Civil Rights Movement and the more recent campaign to elect the first Black President of the United States, to include the experiences of individual congregation members as well (Chatters et al., 2011; Starling, 1999).

Often, these individual experiences include the mental health needs of congregation members. In fact, the Black Church has been referenced as a psychiatric hospital for those in need of help but who either cannot afford or choose not to seek it in

professional settings, leaving the pastor to fulfill the roles that would be otherwise served by mental health professionals (Gilkes, 1980). In the Black church, pastors are valued as credible sources for assistance with social and psychological problems because of their status as pastor, often regardless of the pastor's educational background, knowledge of mental health issues, and previous experience (Kane & Greene, 2009). Although researchers have examined help-seeking among African Americans (Ayalon & Young, 2005; Cruz, Pincus, Harman, Reynolds, & Post, 2008; Neighbors et al., 2007; Townes et al., 2009), researchers also have indicated a need for empirical information about the role of pastors in influencing the mental health help-seeking behaviors of African Americans (Mattis et al., 2007).

Purpose of the Study

Researchers have shown that African Americans tend to seek professional counseling at a much lower rate than other racial and ethnic populations. Instead, African Americans often choose their spiritual leaders as resources for their mental health needs (Ayalon & Young, 2005; U.S. Department of Health and Human Services, 2011). Researchers have found that African Americans hold certain beliefs and receive various messages from pastors, family members, friends, and fellow congregation members regarding their mental health which, in turn, affect their proclivity for seeking professional help. For example, one study found that many African Americans believe that the solution to mental health problem (Newhill & Harris, 2007) can be found in religion, which could possibly explain their tendency to utilize their pastors to meet their mental health needs. Further, researchers have identified existing myths about the mental

health profession in the African American community, including beliefs that mental illness is contagious, people who are suffering with various illnesses are dangerous, and people receiving treatment have no choice or sense of power in their recovery process, which possibly deter help-seeking behavior (Mishra, Luckstead, Gioia, Barnet, & Baquet, 2008).

There is still so much that remains to be known, however, about the motivations, beliefs, attitudes, and influence of pastors on the help-seeking behaviors of those in their care. Therefore, the purpose of this study will be to investigate the response of pastors to parishioners dealing with anxiety, depression, unemployment, anxiety, familial issues, and bereavement; their motivations to encourage or discourage help-seeking outside of the Black Church; their perspectives on secular mental health services in their community; their perspective on spiritual, biological, psychological, and social coping methods; and their beliefs about identifying and responding to adaptive and maladaptive religious coping strategies. By using a qualitative methodology, this information will be gained through semi-structured interviews from the pastors themselves, allowing them to tell their own stories in their own words.

The results of this study will inform counseling with African American clients who have been shaped by the culture of the Black Church. With increased knowledge of a client's spiritual and religious lives, counselors can provide services with an increased level of empathy (Wiggins, 2011). Researchers have identified collaborations between community health providers and pastors of the Black Church as a cost effective means to deliver mental health services to African Americans (Sternthal, Williams, Musick, &

Buck, 2012), and results from this study could help inform and initiate more communication between the two institutions.

Statement of the Problem

In general, African Americans are less likely to seek help for mental health issues, including depression and anxiety. When African Americans have unmet mental health needs, they are less likely to attain an overall positive measure of health and well-being (U.S. Department of Health and Human Services, 2001), possibly contributing, at least to some extent, to the social struggles in the African American community (Youman et al., 2010), including elevated levels of incarceration (Liptak 2008), substance abuse (U.S. Department of Health and Human Services, 2010), and poverty (U.S. Department of Health and Human Services, 2001). For example, when African Americans suffer with depression and anxiety (Himle et al., 2009), the symptoms appear to be more severe and it is more difficult for them to remain committed to their normal routines (Gonzalez et al., 2010), making it important that researchers investigate the type of help and support they receive. The topics of help seeking, the Black Church, and how the perspectives of African American pastors influence this process, then, are important for exploration.

Research Questions

The following research questions will be addressed in the current study:

1. How often do African American pastors have congregation members disclose mental health issues, such as anxiety, depression, bereavement, unemployment, and relationship issues?

2. How do African American pastors respond (behaviorally) to congregation members who are seeking their counsel on issues related to anxiety, depression, bereavement, unemployment, and relationship and parenting concerns?
3. What factors influence African American pastors' decision on whether to refer members of their church to seek mental health services outside of the church?
4. How do African American pastors perceive mental health service delivery in their community?
5. Do African American pastors encourage religious coping behaviors that neglect or recognize biological, psychological, or social factors? Further, do they distinguish between adaptive and maladaptive religious coping?
6. How do African American pastors apportion anxiety and depression across biological, social, psychological, and spiritual spheres of influence?

Need for the Study

The in-depth investigation of pastors and their role in mental health help-seeking behaviors is much needed. Mattis et al. (2007) acknowledged that the integral role of the Black Church has been recognized, but detailed information needs to be known about how the services are carried out. Additionally, Neighbors (1985) and Armour, Bradshaw, and Roseborough (2009) suggested that future research on African Americans should not be limited to comparing them to other racial groups, but rather researchers also should conduct investigations that focus exclusively on African Americans. The fact that pastors have influence is well established (Billingsley, 1999; Mattis et al., 2007; J. D. Roberts,

1994). What is less clearly understood, though, is *how* they influence parishioners. The results from this study will inform both counselors and counselor educators on the culture of the Black Church, and likely have implications for future practice and research.

Definition of Terms

The following is a list of key terms that will be used in this study.

African American is the term used to describe a population of people whose ancestors originated in Africa (Welch, 2010). Often, the terms *African American* and *Black* are used interchangeably. The two terms are synonymous and both will be used throughout this study to refer to this population.

Anxiety is a state in which one may be worried about life situations such as work, relationships, or health (American Psychiatric Association, 2000). Anxiety can cause sleep disturbances and other somatic symptomatology such as sweating, shortness of breath, and panic attacks (Anxiety and Depression Association of America, 2012).

Depression is a state of being in which one has a saddened mood and is likely to have loss of interest in people, places, and activities that they used to find pleasurable and enjoyable. Depression can manifest in several ways, including loss of appetite, weight loss or gain, oversleeping, and insomnia (Anxiety and Depression Association of America, 2012; American Psychiatric Association, 2000).

Help Seeking Behaviors refers to the proclivity of a person to reach out or refute services designed to provide treatment for various health concerns (Townes et al., 2009).

Mental health is a state of well-being in which a person is able to participate in everyday routines of life and be a positive contributing member of their community. One

of the signs of good mental health is one's ability to cope with difficult life circumstances (Joubert, 2010).

Pastor is defined as a ministerial leader of a Protestant church who has been ordained by an authority in their faith community (Payne, 2009).

Religion is the set of beliefs that one holds that usually coincides with a particular organization or a "social context within which a set of beliefs, practices, and experiences occur" (J. S. Young & Cashwell, 2011, p. 9).

Spirituality is "the ability to surpass self-limitations, yet remain centered and grounded". It is also the "realization that all is sacred, leading to the experience of awe and wonder in everyday life" (J. S. Young & Cashwell, 2011, p. 7), influencing one's lives, behaviors, and thoughts (Hadzic, 2011). Spiritual beliefs can involve a particular religious orientation, but may also be areligious, and are considered to be more of an individual experience (Hall, Dixon, & Mauxey, 2004). In other words, one can be spiritual without necessarily being religious.

Black Church, also referenced as the Negro Church by earlier literary scholars such as W. E. B. Dubois, is defined as a church with a predominately African American congregation and led by an African American pastor (C. E. Lincoln & Mamiya, 1990). The Black Church is an overall institution that encompasses individual congregations that meet the criteria noted above. Often, the terms *African American Church* and *Black Church* are used interchangeably (Giger, Appel, Davidhizar, & Davis, 2008) and will be used interchangeably throughout this study as well.

Brief Overview

This research study will be delineated into five chapters. The purpose of Chapter I was to introduce the topic and provide the purpose, rationale, need for the study, research questions, and definition of key terms. The objective of Chapter II is to synthesize and integrate the existing literature to provide the reader with relevant background content about help seeking behaviors of African Americans, anxiety and depression, religion and religious coping in the African American community, the Black Church, and African American pastors. Chapter III provides an explanation and overview of the qualitative methodology chosen for this study. In Chapter IV, the researcher will disseminate the results of the study, which will be presented in a manner reflecting the qualitative nature of the study. In the final chapter, Chapter V, the author will discuss how the results can inform the practice of counseling, counselor education, and future research.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

> A good way to understand a people is to study their religion. (C. E. Lincoln & Mamiya, 1990, p. xi)

Introduction

In Chapter I, a number of challenges facing the black community, including anxiety, depression, familial concerns, unemployment, and bereavement, were introduced. Additionally, the concepts of religion and spirituality in the Black community, including the central influence of Black pastors, were briefly defined and the research questions for the current study were explicated. In the following chapter, these previously introduced concepts will be expounded upon as the foundation for the proposed study that will be described in Chapter III.

Challenges in the Black Community

There are a number of psychological, social, and physical issues that currently afflict the black community and which could warrant discussion in the following exposition. As mentioned in Chapter I, the black community is often disproportionally represented among people struggling with such issues as diabetes (American Diabetes Association, 2012), heart disease (U.S. Department of Health and Human Services, 2010), prostate cancer (U.S. Department of Health and Human Services, 2012), HIV/AIDS (U.S. Department of Health and Human Services, 2001), and breast cancer

(U.S. Department of Health and Human Services, 2012). Further, African Americans often are disproportionally represented in disadvantaged populations that include the homeless (National Coalition for the Homeless, 2009), lower socioeconomic statuses (U.S. Department of Health and Human Services, 2010), incarcerated (Liptak, 2008), and substance abusers (U.S. Department of Health and Human Services, 2001). One reason that a primary focus of the current study is on anxiety and depression is because many of these physical health and social issues could occasion anxiety and depression (Stotland, 2012). Similarly, pastors will be asked about African Americans' experience of bereavement, family issues, and unemployment as these issues often are related to and affected by the issues previously mentioned. Each of these mental health issues (anxiety, depression, bereavement, family issues, and unemployment) will be examined in more detail.

Anxiety

Anxiety can be defined through formal diagnostic interpretations as well as subclinical experiences of anxious symptomatology. According to the DSM-IV (American Psychiatric Association, 2000), anxiety includes a class of disorders that include specific diagnoses such as generalized anxiety disorder, acute stress disorder, panic disorder, panic disorder with agoraphobia, specific phobia, social phobia, post-traumatic stress disorder, and obsessive compulsive disorder (American Psychiatric Association, 2000; Hunter & Schmidt, 2010). Although some people may not meet clinical criteria for diagnoses, they may still experience some symptomatology of anxiety delineated in the DSM-IV; such people are said to experience sub-clinical levels of

anxiety (Hunter & Schmidt, 2010), which may nonetheless reduce their quality of life. Some of these symptoms common in anxiety include physical manifestations such as muscle tension, restlessness, interruptions in normal sleep patterns, irritability, difficulty concentrating, and increased heart rate (American Psychiatric Association, 2000).

African Americans are not the only group of people who experience anxiety. In fact, anxiety affects a significant portion of the general population, with prevalence estimates as high as 18% of adults in the United States (Anxiety and Depression Association of America, 2012; Latzman et al., 2011). Anxiety is problematic as those with an anxiety disorder are at an increased risk for hospitalization. In fact, people diagnosed with an anxiety disorder are five times more likely to see a doctor than the general population and six times more likely to be hospitalized (Anxiety and Depression Association of American, 2012). It is important to note, however, how anxiety may specifically be affecting African Americans uniquely.

Admittedly, the research pertaining to anxiety in the African American community could be described as complex, contradictory, and somewhat confusing (Carter, Sbrocco, & Carter, 1996). Through various research methodologies, some researchers have indicated that African Americans experience anxiety disorders at a lower rate when compared to Caucasian Americans (Chapman & Stager, 2012; Soto, Dawson-Andoh, & BeLue, 2011) while other researchers have found a higher prevalence in the African American community (Himle et al., 2009). Further, much of the existing research related to African Americans and anxiety disorders focuses specifically on panic disorder, panic disorder with agoraphobia (Carter et al., 1996) and post-traumatic stress

disorder (PTSD), although the category of anxiety disorders is more expansive and can include social anxiety, obsessive compulsive disorder, generalized anxiety disorder, and specific phobias (Hunter & Schmidt, 2010), as well as subclinical levels of anxiety that nonetheless may impact quality of life.

Beyond prevalence; however, it also is important to consider African Americans' experience of anxiety and how the two may be mutually influencing one another. Some researchers have proposed that the nature of African Americans' experience of anxiety and how they interpret symptomatology could be impacting prevalence data. It seems that African Americans tend to interpret anxiety symptomatology differently than Caucasians and these cultural differences potentially influence the accuracy of assessments and diagnoses which, in turn, could produce inaccurate prevalence data (Carter et al., 1996; Hunter & Schmidt, 2010). In fact, some researchers have proposed that the discrepancies in prevalence rates could be attributed to environmental factors and cultural influences that often are not considered by researchers. For example, African Americans' experience of anxiety can be influenced by additional variables such as cultural mistrust, experiences of racism, and a hyper-awareness of physical illnesses. For example, an African American may experience hyperawareness about being a minority and the possibility of discrimination which could also be considered as indicative of social phobia by some observers; however, for many African Americans this behavior is normal and, in a sense, protective. Thus, African Americans may be hesitant to report this type of behavior as anxiety and, accordingly, they would not be included in prevalence data (Hunter & Schmidt, 2010).

When discussing the African American experience of anxiety, researchers have noted the importance of specifically addressing the influence of racism. In effect, racism is especially influential and significant to consider. In fact, experiences of racism have been shown to predict Generalized Anxiety Disorder (Soto et al., 2011). Unfortunately, African Americans experience incidents of overt racism five times more often than Whites which, in turn, could increase the likelihood of experiencing anxiety (Soto et al., 2011). African American women may be particularly at risk because of their classification as a "double minority" and the increased likelihood of experiencing discrimination because of these statuses. When asked, however, African American women tend not to identify as being anxious, but instead they tend to consider these experiences as a normal part of their lives and not warranting special attention (Neal-Barnett & Crowther, 2000). Because of these cultural complexities, some experts have proposed separate diagnostic criteria for African Americans while others argue that this is not a sufficient solution (Hunter & Schmidt, 2010; Neal-Barnett & Crowther, 2000). What does seem apparent, though, is that more careful attention should be paid to cultural issues by researchers, as variability introduced by sampling, measurement, and analytic issues could all be adding to mixed and, at times, contradictory findings (Latzman et al., 2011).

An additional question is how conflicting prevalence data and corresponding cultural considerations may be impacting how African Americans respond to anxiety in terms of help-seeking, coping, and treatment. Neal-Barnett and Crowther (2000) found that only 2 out of 15 African American women diagnosed with an anxiety disorder sought

professional counseling help specifically for their anxiety. Instead, they were more likely to engage in counseling for issues such as bereavement, relationship difficulties, and sexual assaults. In this study, the majority of the participants struggled, in particular, with a simple phobia. Many of the participants deferred treatment, however, as they attributed anxiety to being a part of the African American experience and thought the notion of the "strong black woman" to be a sufficient coping strategy and response (Neal-Barnett & Crowther, 2000).

Often, researchers consider race in post-hoc analyses but it is important to consider race a-priori as well (Neal & Turner, 1991). A more concerted effort in including African Americans in research about anxiety is vital to help provide clarity in the existing literature. Researchers have noted that African Americans who possess a fervent racial identity and are more acculturated into the majority culture tend to be more receptive of the mental health institution and may be better able to articulate their experiences with anxious symptoms This implies that researchers may have to be more intentional about recruiting other African Americans who feel mental health providers and researchers represent a majority culture that is not cognizant or sensitive to their needs (Carter et al., 1996). Having more accurate rates of prevalence can improve the state of the current research and could allow practitioners to make better informed decisions pertaining to education, outreach, and treatment (Himle et al., 2009). Further, Soto et al. (2011) challenged providers to be more empathetic towards African Americans' experience because of the contributing environmental factors. The current study can help supplement the current research gaps pertaining to African Americans'

experiences of anxiety. Further, inclusion of the Bio-Psycho-Social-Spiritual model as a theoretical perspective can direct practitioner and research attention to the additional variables of biological, psychological, social, and spiritual influences on anxiety. In particular, a point of emphasis in the current study is how clergy members understand and conceptualize anxiety and how this informs their conversations with, and directives to, their parishioners who struggle with anxiety.

Depression

Depression has been widely explored by researchers and scholars from various disciplines from medical professionals, mental health professionals, and literary notables (Stotland, 2012). Depression warrants this attention as researchers have predicted by the year 2030 it will be among the three leading diseases in the world, along with HIV/AIDS and heart disease (Mathers & Loncar, 2006).

Like anxiety, people experience depression at both clinical and subclinical levels. According to the DSM-IV (American Psychiatric Association, 2000), depression can occur as a single episode or be recurrent; is categorized as mild, moderate, and severe; and can occur with or without psychotic features. Many people experience depressive symptoms but for various reasons are not clinically diagnosed (Scott, Matsuyama, & Mezuk, 2011) or accounted for in prevalence data, yet these people are clearly affected by their symptoms. Common physical indicators of depression include changes in mood, appetite, sleep, energy, and concentration. Additionally, depression can manifest emotionally with feelings of guilt, worthlessness, helplessness, and hopelessness (Stotland, 2012) and impede everyday functioning and normal routines (Cuijpers,

Beekman, & Reynolds, 2012). Moreover, depression can negatively affect marriages, parenting relationships, financial status, and employment and increase the likelihood of teen pregnancy, all issues that have significant relevance to the Black community (Kessler, 2012). Researchers have offered information about the burden of depression on the general population but also challenge that more specific studies should be conducted to explore differences in experiences of depression among racial and ethnic minority groups (Gonzalez et al., 2010) and consider historical and contextual factors (Das, Olfson, McCurtis, & Weissman, 2006; Hunn & Craig, 2009). Without this specific focus on ethnic minorities, crucial information about the African American experience may be lacking (Gonzalez et al., 2010).

There are various etiological beliefs and presentations of symptomatology that seem common to the African American experience of depression. African Americans often face stress, leading to depression, related to issues that may disproportionately affect the Black community. For example, African American women may experience stress and depression related to high incarceration rates of African American men as these men are often their partners, sons, fathers, or other relatives (Hunn & Craig, 2009). Even with these stressors, African Americans may actually underreport their symptoms of depression (Baker, 2001). Additionally, Blacks may present differently when they are depressed, which can impact assessment, diagnoses, and treatment. For example, depression can resemble anger and irritability in many African American clients. It is crucial that clinicians are aware of these variations in order to diagnose and treat African Americans appropriately (Baker, 2001). In fact, African Americans often have a more

difficult time functioning with their depressive symptoms when compared to other racial populations and thus need effective treatment (Gonzalez et al., 2010).

Researchers also have found differences in treatment preferences and coping strategies employed by African Americans dealing with symptoms of depression. More broadly, scholars have debated the idea of recovery, what it entails, and how it should be conceptualized. Currently, recovery from depression is defined as decreased or even eradicated symptomology but scholars question whether recovery equates significant mood improvement even in the midst of bereavement, financial crisis, and difficult parenting situations (Stotland, 2012). Therefore, it is important to understand the etiology and treatment of depression specifically in the African American community, as African Americans often have unique and disproportionate experiences of the aforementioned life stressors. Although African Americans tend to have more severe and chronic experiences with depression, and as a group they tend to be more economically challenged in their ability to seek and receive treatment.

Typically, African Americans are less receptive to pharmacological recommendations when compared to Whites and Hispanics. Often, African Americans believe that anti-depressants are addictive and habit-forming and, therefore, not an option (Cooper et al., 2012). Similarly, African Americans also tend to be less receptive to counseling as a form of treatment for depression, commonly reporting that they are fearful that counseling will exacerbate their current state by eliciting more negative emotions (Cooper et al., 2012). Perhaps this helps explain why they are less likely than other ethnic minorities to receive structured therapeutic interventions for treatment

(Gonzalez et al., 2010). Further, African Americans seem to be more dependent on services provided by their primary care physician for treatment (Das et al., 2006) of depression symptoms, which is important information as treatment settings influence diagnostic attributions of depression. So, medical professionals are more likely to offer physical explanations for the experience of depression, which, in turn, influences their recommendation for treatment (Scott et al., 2011).

It appears that African Americans use religion and spirituality as coping methods for depression and often attribute mood improvement to religious and spiritual influences (Baker, 2001). Nonetheless, some African Americans may not acknowledge their symptoms and begin to overexert themselves in areas of their life (i.e. work) in order to cope with their unsettling feelings (Baker, 2001). Like other areas pertaining to the Black community, researchers assert the need for more research about barriers to depression treatment among African Americans (Das et al., 2006). Accordingly, the current study has a primary focus on pastors' understanding of the etiology and treatment of depression and how this influences their work with parishioners.

Bereavement

Like depression and anxiety, experiencing bereavement is not unique to the African American community as people from all demographic variables encounter losing a loved one through death (Laurie & Neimeyer, 2008). Throughout this chapter, the terms *grief* and *bereavement* will be used interchangeably as is common in the scholarly literature. While grieving is considered a normal experience, there are certain circumstances in which it could be considered unhealthy and counterproductive

(American Psychiatric Association, 2000; Burke, Neimeyer, McDevitt-Murphy, Ippolito, & Roberts, 2011). In some cases, bereavement has clinical implications, as it is included in the DSM-IV as a diagnosis. Criteria included in the disorder are similar to those of Major Depressive Disorder; however, those diagnosed with Bereavement Disorder typically experience guilt related to the loved one's passing and hallucinations related to the deceased person, among other symptoms (American Psychiatric Association, 2000). Some controversy exists over the distinction between a hallucination, which would be considered pathological, and a vision, which would be considered a spiritual experience (Cashwell & Young, 2011). Sometimes these symptoms are also referred to as *complicated grief.*

Mourning is a term related to bereavement that researchers and scholars use in the literature. As Schoulte (2011) noted, "mourning is the term for culturally-informed practices through which grief is expressed" (p.11). While loss itself is a common experience across population groups, the experience of bereavement can vary across cultural groups (Fitzpatrick & Tran, 2002) and it is important for researchers and practitioners to note and be sensitive to these differences. One of the ways the bereavement process varies among different communities is by rituals and practices. For example, common rituals and practices in the African American bereavement process include gathering of family and friends at the home of the deceased or close family member, taking food to the grieving family, a "wake" prior to the memorial service, an energetic memorial service, and repast following the service. Ironically, although African Americans are typically members of lower socioeconomic status groups and often are

considered economically disadvantaged when compared with other racial groups, they typically expend more financial resources on funerals compared to other groups. This could be attributed to their perspective on death and the accompanying rituals. Commonly, instead of viewing death as a final and sorrowful event in one's life, it is actually conceptualized as a celebration, a "homegoing" of sorts, and an escape from the pain and suffering of this present life (Collins & Doolittle, 2006).

Not only have researchers found that African Americans may respond behaviorally different than other groups in the mourning process, it also appears that they may respond differently physiologically and psychologically. For example, researchers have found that African Americans' physical and mental health tend to be less negatively affected by bereavement when compared to Caucasians. One possible explanation is attributed to the social support often received by African Americans can moderate the bereavement experience (Fitzpatrick & Tran, 2002).

While these protective factors, such as support of extended family and friends, are important, they do not eliminate the possibility of African Americans experiencing complicated grief. For some mourners, grief can be complicated by the religious and spiritual struggles that are associated with the process. When confronted with other life stressors, some may typically respond with religious coping mechanisms. Although spiritual practices and rituals can provide a sense of comfort in other difficult situations (Collins & Doolittle, 2006), researchers have suggested that these coping strategies may not be sufficient to guide them through the bereavement process (Burke et al., 2011). Further, when religious and spiritual coping strategies are inadequate, the question arises

whether African Americans seek help from additional resources and if so, what are these resources and what services, if any, are provided.

Collins and Doolittle (2006) suggested that it is possible for researchers and clinicians to misunderstand the African American grieving process because of the lack of experience and exposure. The current study will help provide insight into instruction received by African Americans from their spiritual and religious leaders, namely their pastors. As stated briefly in Chapter 1 and more thoroughly discussed in this chapter, when discussing the African American experience, it is helpful, and perhaps even necessary, to incorporate the influence of religion and spirituality and nowhere is this more apparent than in coping with loss.

Familial Issues

Along with the Black Church, scholars have referenced the African American family as one of the "enduring institutions" of the Black community. Although some historians reference the Black family with this fondness, it seems that the majority of the literature pertaining to the Black family is problem oriented and deficit focused as low-income, high risk families tend to be overrepresented in participant samples and low-risk middle class families are underrepresented (Tamis-Lemonda, Briggs, McClowry, & Snow, 2008; Wiley, Warren, & Montanelli, 2002). There are many aspects of the Black family that could serve as focal points, but parenting and intimate relationships will be primarily explored for the purpose of this study. The literature discussed in this chapter will acknowledge the challenges that African American families face in parenting and

relationships and identify coping resources that will be further explored in the current study.

Parenting. Parenting in the Black community can be particularly challenging and warrants attention in the current study (Paschall, Ringwalt, & Flewelling, 2003). Some of these challenges include discrimination (Paschall et al., 2003), the disproportionate number of grandparents who are primary caregivers in the Black community (U.S. Census Bureau, 2000), absentee fathers (C. A. Smith, Krohn, Chu, & Best, 2005), unemployment, and other economic constraints (Wiley et al., 2002). African American children and adolescent males are often the primary focus of the current parenting literature, perhaps due to their proclivity to be counted among at-risk populations and involved in delinquent behaviors. Along with African American males, African American single parent mothers also are heavily studied (Paschall et al., 2003). Because of the unique challenges African Americans face, American parents often find themselves acting as buffers for their children against societal challenges, such as discrimination that they will likely encounter because of their race (Coard, Foy-Watson, Zimmer, & Wallace, 2007; Simons et al., 2006). In fact, it seems that supportive parenting can significantly diminish the likelihood that African American males will have violent responses to incidents of discrimination and mitigate the harmful effects that these experiences of racism will have on African American males (Simons et al., 2006). What remains unknown is exactly what is involved in supportive parenting and how this produces these significant differences in children's responses (Simons et al., 2006).

Although the focus of researchers appears to be on deficits in the African-American family, some researchers have found promising, more positive results. Traditionally, much of the literature has focused on single mother households, neglecting the influence of the father. C. A. Smith et al. (2005) found that African American fathers provide for their children and consider themselves to be an important figure in their child's life. Further, some researchers have found that an absence of a father figure in the household does not necessarily predict delinquent behavior in a child (Paschall et al., 2003).

With regards to support, it seems that African Americans rely heavily on religious resources but remain open to alternative forms of support from formal helping professionals like counselors. When parents were invited to be a part of interventions that were culturally relevant, they seemed heavily invested; however, they seemed significantly less likely to participate in activities that seem to neglect important parts of their culture (Coard et al., 2007). It seems that the key to providing successful parenting interventions in the Black community is cultural sensitivity to language and a collaborative approach that includes extended kin as a significant part of the parenting process (Coard et al., 2007; Tamis-Lemonda et al., 2008).

Researchers also acknowledge that additional research on the Black family is needed so that helping professionals can respond with more effective and culturally appropriate interventions (Fincham, Ajavi, & Beach, 2011; Tamis-Lemonda et al., 2008). Further, researchers have noted the potential of qualitative research to gather specific information and increase knowledge and understanding of phenomena like African

American parenting that has been previously misunderstood or misrepresented (Tamis-Lemonda et al., 2008). In fact, "qualitative research sheds light on why parents choose the strategies they do in the rearing of their children" (Tamis-Lemonda et al., 2008, p. 38). This current study will quantitatively investigate the possible influence of pastors on these strategies as well as answer the call of researchers such as Wiley et al. (2002) to investigate support systems of African American parents in order to shift the focus of the literature from deficit based to a more balanced representation of the African American community.

Intimate relationships. The culture of Black intimate relationships, in particular Black marriages, is an under-explored phenomenon in the current couples and family literature. Researchers have noted the importance of exploring how culture and ethnicity affect the way people conceptualize the idea of marriage which, in turn, impacts their opinion of the overall family institution (Bryant et al., 2008). Some of these specific cultural variables that have started to appear in the literature include complications and subsequent coping responses within the African American community.

Like parenting, it seems that African American couples may face certain challenges in maintaining healthy relationships and combating high divorce rates. Further, it is likely that these challenges may contribute to the high number of African Americans who remain unmarried. Some challenges noted by African Americans included trying to balance work and familial obligations and stress caused by extended family members. For example, African Americans have noted how providing financially for extended family members can cause increased tension between partners (Marks,

Hopkins, Chaney, Monroe, & Sasser, 2008). Other challenges noted by researchers include high unemployment rates of African American men, low educational attainment, the experience of discrimination (Fagan, 2009), and the perceived unavailability of eligible Black men (Bryant et al., 2008). In a study of African American adolescents, researchers found that African American adolescents were more optimistic about their future careers than their future relationships and families. Additionally, these adolescents believed that they had more control of their career trajectory than their ability to maintain healthy, long-lasting relationships (McCabe & Barnett, 2012). Because of these identified challenges and attitudes and beliefs about African American relationships, some researchers have shifted their focus to investigate how African Americans may be responding to these challenges and protective factors that are potentially undiscovered.

Religion and spirituality have been identified in the literature as helpful coping strategies and essential support systems for many African American couples. Some of the specific strategies used by couples include spiritual practices such as prayer, worship, and fasting (Marks et al., 2008). In fact, research by Finchman et al. (2011), considered groundbreaking because of their exclusive focus on African American couples, used pastors to recruit participants for their study of relationship satisfaction and spirituality. While other studies have identified religious coping as a resource (Marks et al., 2008), it seems that this body of literature needs to be expanded with more in-depth investigations. Finchman et al. (2011) challenged future investigators to focus on what specific facets of spirituality influences quality and satisfaction of marriage. It is likely that the current

study will inform this gap by focusing on the instructions that pastors may provide to couples that seek their guidance during difficult phases of life.

Unemployment

Historically, there has always been a substantial gap in unemployment between African Americans and Caucasians, with African Americans having significantly higher rates of unemployment. During the 1970s, the unemployment rates were most similar between Whites and Blacks. Since then, however, the gap has continued to expand. Although researchers and scholars have acknowledged this gap over the years, there seems to be a lack of appropriate attention to this subject matter in order to stimulate change (Kroll, 2012). Further, Blustein, Medvide, and Wan (2011) noted that unemployment is a complex issue that should be analyzed more critically by both researchers and clinicians.

Often, African Americans are disproportionately represented in unemployment percentages. Further, even when they are employed they tend to be underemployed or in lower wage earning positions. Researchers have indicated various explanations for the disparities and challenges African Americans may face when seeking gainful employment that date back to civil rights, segregation, and Jim Crow laws (Rodriguez, Allen, Frongillo, & Chandra, 1999). Moreover, many inner-city manufacturing employers that hired a number of Blacks were outsourced to suburban areas making it difficult for Blacks to get to work. More current explanations have been offered as well. For example, high incarceration rates of African Americans decrease the pool of available workers. Even after being released from prison, many ex-convicts are

considered ineligible hires by many employers (Kroll, 2012). African Americans also often have less education than other eligible workers, which may negatively affect their chance of securing employment (Blustein et al., 2011; Kroll, 2012).

The above average unemployment rates seem to induce emotional, psychological, and physical health consequences for African Americans. Many feel shamed about their employment status (Blustein et al., 2011) and often become depressed as a result (Rodriguez et al., 1999). Additionally, researchers have associated unemployment with negative health outcomes in the Black community. What is less well understood is what coping strategies may be used to buffer these consequences (Rodriguez et al., 1999).

Summary

The aforementioned issues of anxiety, depression, bereavement, familial issues, and unemployment are by no means isolated to the Black community, but researchers have suggested specific needs of African Americans related to these issues. While it seems apparent that these issues are occurring, the question arises as to how African Americans seek help for these struggles.

African American Help-Seeking Behaviors

One important area of scholarly focus is African Americans' use of mental health services. At a broader level, researchers have concluded that it is vital to extend the definition of help-seeking to include presenting concerns that may not be biological in origin or specifically health-related, namely those that are mental health related (Neighbors, 1985).

Compared to other racial and ethnic groups, African Americans are less likely to engage in professional counseling from formal mental health providers (Ayalon & Young, 2005). This is especially true when comparing African Americans to Caucasian Americans (Woodward, 2011). In a recent empirical investigation of help-seeking, one out of four African Americans reported they solely relied on informal resources for help with mental disorders (Woodward, 2011). Moreover, as low as the rates are for seeking general mental health services, the rates for seeking specialized care from clinicians for specific illnesses is much lower (Gallo et al., 1995) and often therapy is seen as more of a luxury than a necessity (V. L. S. Thompson, Bazile, & Akbar, 2004). Not only does it seem that African Americans are not seeking help for mental health issues, but they also are more likely to have negative feelings concerning treatment (Connor, Koeske, & Brown, 2009). Because of this proclivity to avoid formal help-seeking, more African Americans are likely to seek treatment only after the symptoms have progressed in severity to the point that the only viable options they see for treatment are emergency room and hospitalization services (Krause, Ellison, Shaw, Marcum, & Boardman, 2001). Emergency rooms are viewed as one of the most secure places to seek help for a variety of issues as African Americans have articulated that they cannot be denied treatment based on their inability to pay for services (V. L. S. Thompson et al., 2004).

Although African Americans do not seek help at the same rates of other populations, researchers have been able to distinguish some characteristics of African Americans who are more likely to utilize health care services. Typically, African American consumers tend to seek help for suicide, schizophrenia, and depression (V. L.

S. Thompson et al., 2004). Education also appears important, with African Americans with higher levels of educational attainment being more likely to seek help from formal settings (Broman, 2012). It also appears, however, that income level and financial status may be an even more significant predictor of help seeking behaviors as researchers have found that people, both White and African American, who were struggling financially were less likely to seek and receive services (Diala et al., 2000). Finances are particularly relevant to African American as they are often more economically disadvantaged than Whites (United States Census Bureau, 2010). similarly, gender appears to influence help-seeking behaviors, with African American women being more likely than men to seek help from professional mental health providers (Neighbors, Musick, & Williams, 1998, Neighbors et al., 2007). Further, African Americans who have been married but since separated or divorced appear to be more likely to use services from formal mental health care clinicians (Neighbors et al., 2007).

Although there are several hypotheses proposed by researchers and reported by African Americans themselves, one of the prevailing rationales cited by African Americans for underutilization of services include the history of resiliency in having to cope with difficult living conditions such as slavery and other forms of oppression. Although legalized institutional oppression is no longer as prevalent as it was during previous decades, the ramifications of this maltreatment leaves African Americans less likely to become consumers of health care services (Chandler, 2010). Many African Americans note that they are accustomed to suffering and even have an expectation of difficult life situations and therefore do not see a need for help (Chandler, 2010; Krause

et al., 2001; V. L. S. Thompson et al., 2004). For example, researchers found that Black women suffering from anxiety circumvented formal counseling services because of the belief that they were expected to be "strong black women" (Neal-Barnett et al., 2011) as historically they have been viewed as the anchor of the Black family (V. L. S. Thompson et al., 2004). Similarly, African American men have noted a sense of pride that is compromised by seeking professional help for mental health issues (V. L. S. Thompson et al., 2004).

Attitudinal Barriers

Scholars have been able to identify possible barriers, attitudinal and structural, that hinder African Americans from participating in secular mental health treatment settings (Alvidrez, Snowden, & Kaiser, 2008). Whereas structural barriers tend to be more related to external circumstances like insurance coverage and access to health care, attitudinal barriers tend to stem from internal belief systems (Alvidrez et al., 2008). Because the primary focus of this study is on attitudes, the focus here will be on attitudinal barriers. Barriers also can be classified as either internal or external with internal barriers being more related to beliefs within a person. These beliefs can be related to etiology, outcomes, and options for treatment (Ward, 2005; Ward & Heidrich, 2009). It seems that even when structural barriers (i.e. insurance concerns, access) are not an issue, the disparity in help-seeking behaviors persist and there still seems to be some force that hinders African Americans from seeking counseling, namely attitudinal barriers (Alvidrez et al., 2008; Takeuchi, Leaf, & Kuo, 1988; U.S. Department of Health

and Human Services, 2001). Two of the prevailing attitudinal barriers that have been discussed in the literature include stigma and cultural mistrust.

Stigma. Stigma can be conceptualized as *felt* stigma or *enacted* stigma and it "occurs when socially undesirable characteristics become linked with stereotypes about a class of individuals, resulting in social distance from and discrimination towards labeled individuals" (Alvidrez et al., 2008, p. 874). When stigma is *enacted*, it originates from external sources (i.e. family members, helping professionals) that may treat certain individuals differently because of labels or stereotypes (i.e. mental diagnoses). Stigma can be *felt* when the stereotyped individuals fear that they will experience some stigma or discrimination and therefore avoid particular situations when they feel these experiences are more likely to occur (Alvidrez et al., 2008, Scambler & Hopkins, 1986). Higher levels of stigma have been associated with more negative attitudes regarding seeking treatment from mental health providers and it seems that African Americans experience higher levels of public and internalized stigma than Whites (Connor et al., 2009), likely accounting, at least in part, for underutilization of mental health services.

In interviewing African Americans with a diagnosis of depression, researchers (Cruz et al., 2008) found that stigma was identified as the primary barrier to seeking professional mental health treatment. Mental health diagnoses often have pervasive negative connotations in the African American community, influencing African Americans' ability to recognize when they are experiencing problems and even causing then to avoid or delay treatment for these issues (Alvidrez et al., 2008). Cruz et al. (2008) found that the stigma was related to shame experienced by the individuals diagnosed with

depression. Moreover, it seems that many also will deny the severity of their situations to avoid feeling stigmatized (Cruz et al., 2008). In fact, many African Americans believe that issues, which could often influence one's mental wellness, should either be kept within in the family or handled by the individual (Barksdale & Molock, 2008; Kane & Green, 2009). Other researchers have found that even within the family people receive messages, both implicit and explicit, that it is inappropriate to discuss mental health issues (Alvidrez et al., 2008). This added familial pressure can be a deterrent to treatment (Barksdale & Molock, 2008; Kane & Green, 2009). Because of the complexity of these issues and the degree to which these messages have been internalized, even African Americans acknowledge that in order for stigma to decrease in the Black community, there would need to be a complete reorientation of culture. (Awosan et al., 2011). Counselor educators must not only investigate the origins of these messages but must also respond in a culturally sensitive way to help reorient these beliefs.

Cultural mistrust. Scholars have frequently discussed Blacks' distrust of traditionally White institutions (C. E. Lincoln, 1973). Perhaps, Blacks who may be in need of counseling services are hesitant to participate in mental health services because they see it as a traditionally White institution. For example, in a study of rural African American families, parents identified extended family, pastors, and school counselors, but not mental health counselors, as preferred helpers (Murry et al., 2011). Blacks reported having negative experiences that include being inaccurately diagnosed and terminated from their services prematurely. African Americans also are more hesitant, in general, to incorporate psychopharmacology in their treatment and would rather talk with

a counselor, but sometimes feel that more emphasis is placed on the medicine (Chandler, 2010; Nicolaidis et al., 2010). In a study that analyzed racial microagressions (i.e., covert forms of racism or prejudices meant to insult or emotionally wound someone) in the formal counseling helping relationship of White counselors and Black clients, researchers found that when Blacks perceived the presence of racial microagressions, the therapeutic alliance was severely wounded and the counselor was identified by the client as lacking cultural competence. The perception of such microagressions profoundly impacts client satisfaction and places African Americans at risk for re-traumatization (Constantine, 2007). Further, it seems that African Americans place a significant emphasis on confidentiality and fear leaked information in counseling relationships as they may distrust White counselors (Nadeem, Lange, & Miranda, 2008).

Because of this mistrust, one of the barriers that African Americans may face stems from their preference for African American providers. This preference could be problematic as Blacks are an underrepresented population among mental health professionals (Townes et al., 2009). It is possible that Blacks could become frustrated because they do not have the option of choosing a Black counselor because of availability and economic resources. This frustration and fear of disappointment could discourage many African Americans from even trying to seek help (Nicolaidis et al., 2010; Townes et al., 2009; Ward, 2005). Furthermore, Ward (2005) found that some Blacks are hesitant to see White therapists because they believe they may not be able to relate to their issues. In fact, the treatment outcomes of African American clients have been found to be

significantly better when they were paired with an African American therapist (Cabral & Smith, 2011).

Ironically, although African Americans are less likely to utilize services when compared with Caucasian populations, those who choose to seek mental health services often have positive attitudes and expectations about services prior to actual use (Diala et al., 2000). That is, it seems that the negative attitudes, myths, and stigma regarding mental health influence help-seeking behaviors but not necessarily the efficacy of the counseling. Often, once African Americans choose to seek help and overcome help-seeking barriers, they are open to a counseling process that provides them with important support (V. L. S. Thompson et al., 2004). It appears, though, that some African Americans experience something either before or during their first counseling session that negatively impacts their attitude and makes them less likely to return for subsequent sessions, even if they are still experiencing psychological discomfort (Diala et al., 2000). Researchers have argued that future research should focus on learning more about this mistrust and that qualitative methodologies may be an effective way to increase the existing knowledge (Awosan et al., 2011). Additionally, it is imperative that culturally competent professionals are appropriately trained to provide services to diverse populations, which includes assessment methods that consider a client's historical influence (Hickling, 2012).

Religion and Spirituality: Barrier to Treatment or Alternative Resource?

In the midst of attitudinal and structural barriers to mental-health help-seeking behavior, an alternative form and method for seeking help has emerged, that of seeking

help within religious and spiritual communities. For many African Americans, help-seeking from a "higher power" tends to be more culturally accepted than other forms of help-seeking (Andrews et al., 2010). Similarly, Ward and Heidrich (2009) found that most African American women identified religion as a coping mechanism that they would "definitely" use while treatment, from sources such as counseling professionals, was something they would "probably" seek. Further Nadeem et al. (2008) indicated that even when African American women were suffering from depression and somatic symptoms, they were more likely than Latina and White women to believe that their faith would be helpful in dealing with their depression and the accompanying somatic manifestations. When dealing with mental health issues, African Americans for whom God was the core of their external locus of control were less likely to seek help in more formal helping professional settings (i.e. counseling; Ayalon & Young, 2005).

Broman (2012) found that Blacks who received mental health treatment in the past were less likely to be engaging in current treatment. In other words, it seems that Blacks who had once sought help were less likely to do so a second time. Broman offered clinician's lack of sensitivity to client religious and spiritual concerns as one explanation for the discontinuation of services. It is possible, then, that various microagressions, including biases against religion and spirituality, might culminate in a reduced willingness to seek help. Particularly with African Americans with strong religious roots, the potential exists for helping professionals to damage the therapeutic alliance by automatically assuming religious coping methods to be maladaptive (Entwistle, 2009) or avoiding explicit spiritual practices during session (Brown, Elkonin, & Naicker, 2011). If

clients are seeking a religious or spiritual focus in their recovery and healing process, they may circumvent professional helpers and seek out sources that can provide this level of spiritual support. When exploring the mental health help-seeking behaviors of African Americans, it is imperative to pay particularly close attention to the role of religion and spirituality in the fabric of the African American experience.

An additional hypothesis as to why African Americans are less likely to seek mental health services is that when they seek initial psychological support from their Pastors, they are less likely to then seek out other services (Neighbors et al., 1998) implying that somehow they are getting their needs met from these sources. Further, Ward and Heidrich (2009) reported a need for future research to be more intentional about studying the relationship between beliefs held by African Americans and coping strategies. Because the literature in this area is relatively scarce, it seems most appropriate to use exploratory methods, like qualitative methodologies, that allow themes to emerge. This gap also allows future researchers the leverage to explore different populations within the African American community and begin to see how beliefs and attitudes within the community relate to one another and how they may actually influence each other.

What is unclear from the existing body of research, however, is the complex bi-directional relationship between religious and spiritual coping and mental-health help-seeking behavior. That is, does healthy religious coping serve to buffer the individual such that he or she has a reduced need for mental health services? Alternatively, might maladaptive religious or spiritual coping keep an individual from seeking needed mental

health services? Finally, it is unknown to what extent these two social constructs (religious/spiritual coping and mental health help-seeking behavior) mutually influence each other. That is, religious coping appears to decrease mental health help-seeking while the experience of stigma, cultural mistrust, and microagressions from mental health service providers may increase religious and spiritual coping, as some people may not see counseling services as a viable option. Further, it seems important to investigate how religion and spirituality, specifically in the Black community, may be a structural, attitudinal, internal, or external barrier or a positive alternative to mental health help-seeking in other settings.

Religion and Spirituality

Spirituality and religion are important in the lives of many clients, certainly not only those of African descent, and, therefore, are important aspects of assessment and counseling. In the 2009 Council for Accreditation of Counseling and Related Educational Program (CACREP) standards, spirituality, based on the Latin term *spiritualis* (Belcher & Benda, 2005), is defined as "a sense of a relationship with or belief in a higher power or entity greater than oneself that involves a search for wholeness and harmony" (p. 63) and a means by which people are able to answer some of life's difficult questions (CACREP, 2009). This is particularly true for those who are confronted with some sort of traumatic experience, for example a diagnosable illness (Puchalski & Romer, 2000). The original interpretation of the word *spiritualis* meant one who possessed the Holy Spirit, usually a minister (Koenig, 2009). Koenig (2009) argued that spirituality is more difficult to define because of its individualistic nature. At times, it

seems that the core values of spirituality are challenged by the ideas of materialism and individualism that are prevalent in today's society (Eckersley, 2009). In the scholarly literature, religion typically is differentiated from spirituality, as the latter is conceptualized as more individualistic and less organized. Religion, which can be both public and private in practice and rituals (Koenig, 2009; Molock, Puri, Matlin, & Barksdale, 2006), implies a mandate of obedience to a set of creedal beliefs and, among Western religions, belief in a supreme being. Religion denotes a specific idea about life after death and how one should conduct themselves while on earth, as this would likely inform their eternal destination. It is possible for someone to identify as both spiritual and religious; however, it is also possible for someone to identify as spiritual but not religious (Koenig, 2009). For many researchers, religion is often defined by the constructs of church attendance, religiosity, denomination affiliation, religious coping, and spirituality (Powell, Shahabi, & Thoresen, 2003). While a differentiation between religion and spirituality exists amongst scholars, it is not as prevalent amongst practitioners and in fact religion and spirituality appear similar to most practitioners in clinical settings (Bhui, King, Dein, & O'Connor, 2008).

Kuczewski (2007) asserted that helping professionals often are charged to take care of "vulnerable persons facing difficult situations and tragic choices" (p.9) and attending to the spiritual needs of clients is a essential part of developing culturally sensitive treatment plans and recommendations. Counselors graduating from CACREP accredited programs are expected to be able to respond appropriately to spiritual and religious issues that may arise in the counseling process (Robertson & Young, 2011).

Further, counselors should be able to recognize how a client's spirituality and religion are affecting their mental health and overall well-being (Cashwell & Watts, 2010). Even when clients profess no religious or spiritual affiliation and consider themselves atheist or agnostic, it is still important for clinicians to explore this because there is likely vital information behind their decision (Robertson & Young, 2011). When counselor assess a client's spiritual relationship and integrate these conversations in the helping relationship, often they are able to provide a context for the client's current state of psychological discomfort (Puchalski & Romer, 2000). For example, Katerndahl (2008) suggested that when working with a client who seems to be difficult, resistant, and who does not seem to be responding typically to the clinician or to treatment recommendations, it would be advantageous to assess for how the client's spirituality may be influencing their response to treatment. Further, not only can religion and spiritual beliefs influence the treatment process, they also can determine appropriate forms of treatment for clients. For example, there may be certain recommendations that clients may refuse because of their religious and spiritual beliefs (Kuczeweski, 2007) and the contradiction that exists for them between the proposed mental health treatment and their personal religious truths could be difficult to reconcile (Wamser, Vandenberg, & Hibberd, 2011). Additionally, gathering comprehensive information can help counselors determine when to refer to or consult spiritual advisors as many helping professionals often become uncomfortable when a client's belief about healing is juxtaposed to the professional's knowledge of science (Kuczeweski, 2007).

Overall, researchers have found spirituality to be beneficial to clients' overall physical and mental health and wellbeing (Robertson & Young, 2011). Both physical and mental wellbeing involves an ability of people to feel connected and religion and spiritual are often seen as means to those feelings of connectedness (Eckersley, 2007). Although some researchers caution against strict differentiations between mental and physical health (Oman & Thoresen, 2005), scholars often differentiate the two and therefore the author will address the relationship of religion with physical and mental health separately in the following sections.

Religion and Spirituality: Effects on Physical Health

Generally, spirituality and religion have been found to correlate with positive physical health outcomes (Matthews et al., 1998), although the research may be more complicated than it appears on the surface (Powell et al., 2003). Often, physical health is operationalized in terms of mortality (e.g., heart disease, hypertension, stroke, or cancer) (Taylor, Chatters, & Levin, 2004), morbidity, recovery, and disability (Oman & Thoresen, 2005; Powell et al., 2003). Researchers have identified positive outcomes when people engage in religious and spiritual practices that include a decrease in blood pressure (Oman & Thoresen; Matthews et al., 1998) and relief of pain in patients suffering from cancer (Matthews et al., 1998). In their extensive literature review, Oman and Thorsen (2005) also identified a decrease of heart disease as a benefit of religion and spirituality. Further, Powell et al. (2003) found 11 studies that linked frequency of church attendance to an average 30% decrease in mortality rates. In fact, hospitalized patients requested that conversations about their medical treatment include dialogue about their

religious beliefs; however, it seems that physicians, in general, are unlikely to engage in these conversations (Bushwick & King, 1994).

Although the literature that specifically addresses the effects of religion and spirituality in African Americans' physical health it is beginning to grow (Taylor et al., 2004), it remains relatively scarce compared to the existing literature on other racial and ethnic population groups. Some researchers have been able to link religion and spirituality to decreased mortality rates in African Americans (Hummer, Rogers, Nam, & Ellison, 1999; Taylor et al., 2004).

Although many of the aforementioned results seem promising and positive, the literature regarding health and religion is mixed, complex and, at times, conflicting. While some evidence exists to support positive effects on physical health factors such as mortality, other researchers have noted the lack of evidence supporting other measures of physical health, such as recovery from acute illnesses (Powell et al., 2003). Some of this confusion could be attributed to the differing interpretations of the question "Does religion cause health benefits?" (Oman & Thoresen, 2002, p. 370). Oman and Thoresen (2002) proposed that some of these differing interpretations are attributed to the values and beliefs of the researchers. It is likely that qualitative methodologies are needed wherein authors are allowed, encouraged, and sometimes mandated to provide readers with information pertaining to their life experiences, values, and beliefs that could help explain potential biases that arise in the study. Additionally, one's interpretation of health is also crucial as some people are more likely to grant psychological attributes more weight than biological factors in their definitions of optimal health (Oman & Thoresen,

2002). Perhaps, using holistic and more comprehensive theoretical models such as the bio-psycho-social model will allow for more specificity in the derivation of health. Further, the bio-psycho-social model could allow participants the opportunity to consider the biological, psychological, social, and spiritual factors collectively and individually in their interpretation of health. Further, Oman and Thoresen (2002) challenged the objectivity of the question, "Does religion buffer health?" The authors argued that conceptualizations of religion and spirituality could influence interpretations of this question and produce mixed results in the literature. What remains unknown is the extent to which this idea of buffering could be exasperated or interpreted differently in populations that rely so heavily on spirituality and religion. Among such groups, it is likely that spirituality and religion greatly influence their health and their health could influence their religion and spirituality (Oman & Thoresen, 2002).

Religion and Spirituality: Effects on Mental Health

The relationship between religion, specifically Christianity, and mental health has been a topic of interest for many researchers (Jourbert, 2010). The initial seminal articles linking religion and spirituality to mental health, authored primarily by Freud, were primarily negative. In fact, Freud argued that religious beliefs were an indicator of neurosis and mental illness in individuals. After World War II, the literature in this area increased in quantity and improved in quality and shifted towards a more positive perspective (Oman & Thoresen, 2005). Since then, other researchers have found that there are psychological benefits to engaging in spiritual practices (Taylor et al., 2004). Some of these psychological benefits include increased self-esteem (Kelly, 1995;

Matthews et al., 1998), joy, compassion, hope (Oman & Thoresen, 2005), happiness (Taylor et al., 2004), increased social support, respect, purpose, meaning (Diener, Tay, & Myers, 2011), and overall life satisfaction (Taylor et al., 2004). Spirituality can help provide clarity for people who are struggling with difficult life situations such as the aging process, anxiety about death, and sexuality concerns which could increase emotional wellbeing and decrease mental distress (Kelly, 1995; Matthews et al., 1998). In a study of older Caucasians and African Americans, Krause (2009) found that people who indicated having a closer relationship with God also reported having an increased self-esteem and self-worth. In a systematic literature review, Koenig (2009) found that in 2/3 of the existing literature about spirituality and depression researchers reported religion and spirituality as predictors of lower rates of depression and a decrease in the experience of depression symptomatology. Additionally, anxiety can prompt people towards religious and spiritual practices. Researchers have suggested religious coping mechanisms worked more quickly than primarily secular modes and a more significant predictor of improved health when people were both physically and emotionally ill (Koenig, 2009).

Similar to the literature about physical health and religion and spirituality, the literature about mental health and spirituality and religion can also seem confusing and, at times, conflicting. Interestingly, it seems that religion and spirituality both improve and worsen anxiety symptoms. Religion and spirituality has the proclivity to exasperate anxious symptoms when people feel they are not living up to religious expectations. On the other hand, religion and spirituality can provide comfort, a sense of security, social

support, and self-confidence, which seems to decrease anxiety (Koenig, 2009; Wink & Scott, 2005).

Summary and Critique of the Existing Literature

Diener et al. (2011) cautioned researchers from assuming that all religious people are happier, without considering other contextual factors including the society in which they live. One of these contextual considerations could be race and ethnicity. Powell et al. (2003) critiqued researchers who did not pay close enough attention to the demographic variables of participant samples in this literature as they are likely missing important considerations. Not only is the literature somewhat dated, but many of the studies were either predominately Caucasian, race was not specifically included in the analyses, or a lack of descriptive data for African Americans were included in results (Taylor et al., 2004). For example, Jackson and Bergeman (2011) found that religious practices, spiritual experiences, and religious coping were all positively correlated with wellbeing. It is important to note that the participant sample was 87% Caucasian and 36% of the participants possessed a college degree. Moreover, although demographic statistics were provided for readers, it was not a specific part of the researchers' analytic process or discussion in the results section. One could argue that these findings may not be as applicable and generalizable to the African American community because of their lack of representation in the sample (Jackson & Bergeman, 2011). In fact, Taylor et al. (2004) found only 2 surveys that exclusively focused on African Americans. For example, Blaine and Crocker (1995) reported that religion and spirituality was a predictor of life satisfaction for Blacks but not for Whites. Perhaps some of the complexity regarding the

benefits of religion and spirituality could be partially explained by the influence of race and/or ethnicity. Other elements of this complexity could also include the influence of spiritual leaders, particularly with regards to African Americans as pastors have been found to be particularly influential in the lives of African Americans. Hearing the perspectives of African American pastors on religious coping and its effects on mental health could greatly inform the existing literature and help provide some context for readers.

Religious Coping

Many people use spirituality and religion as coping methods because it is a *relatively available* and *relatively compelling* approach to coping (Pargament, 1997). Religion is thought to be *readily available* because of its accessibility compared to other resources such as finances, and social and physical support (Koenig, 2009). Religious coping serves five purposes for people, which include spiritual, self-development, resolve, sharing, and restraint (Pargament, 1997). Often, people redefine their current situation and struggle through a lens of religious coping and, through this, are able to adopt a more positive outlook on their current suffering (Bhui et al., 2008). Tix and Frazier (1998) found that religious coping was more powerful for Protestants than other groups, such as Catholics. Although people who attend church more frequently tend to rely on religious coping strategies more frequently (Krause et al., 2001), religious coping is not limited to those who profess a belief in a higher power or who identify as religious or spiritual (Bhui et al., 2008). Because of the magnitude of the issues facing the Black community, introduced earlier in the chapter and the proclivity for many Blacks to seek

solace in religion and spirituality, it is important to explore religious coping to help provide context for this study.

In religious coping, individuals utilize specific rituals and spiritual practices as ways of coping in an effort to redefine their stressful life incidents. Rather than viewing them as suffering, people may view these stressors as an opportunity to display strength and facilitate personal growth (Bhui et al., 2008). Religious coping, often enacted when people feel threatened or are fearful that some psychological, biological, social, or spiritual goal will not be met (Folkman & Moskowitz, 2004), is seen as a means to manage and reduce negatively charged emotions that often are elicited amidst the stress associated with these critical incidents (Bhui et al., 2008). For example, people often use religious coping when they are faced with existential concerns (Pieper, 2004) that could include death anxiety after receiving a terminal medical diagnosis. Although religious coping is not limited to religious individuals, the particular practices and rituals people use in coping can be indicative of their religious affiliation or spiritual beliefs (Bhui et al., 2008).

Pargament, Smith, Koenig, and Perez (1998) asserted that religious coping styles could be categorized as either adaptive (improve one's condition) or maladaptive (counterproductive to one's growth and healing). Even with these classifications, it is important to remember that people can use different religious coping styles, both adaptive and maladaptive, simultaneously (Bjorck & Thurman, 2007; Pargament et al., 1998). Researchers frequently focus solely on negative reactions to stress but should consider the possibility that stress can elicit either positive or negative reactions or, in some cases,

both (Folkman & Moskowitz, 2004). In other words, these life stressors can encourage people to use adaptive coping, maladaptive coping, or both.

Adaptive Religious Coping

Adaptive or positive forms of religious coping propel many to grow spiritually and psychologically from their crises or stressful ordeals. In other words, it seems that these methods of religious coping can produce emotional, psychological, and physical benefits to individuals (Pargament et al., 1998). Religious coping can create meaning and purpose for difficult life situations and can elicit strength from suffering individuals.

Pargament et al. (1998) classified *seeking spiritual support, religious forgiveness, collaborative coping, spiritual connection, religious purification, benevolent religious appraisal,* and *religious focus* as positive adaptive forms of religious coping. *Spiritual support* involves various aspects that can include an emotional reassurance, a close relationship with God, and guidance in problem solving. *Religious forgiveness* is seen as a means for people to move from bitterness to peace concerning their stressful circumstance. In this coping method, people are able to use their religion as a model to forgive themselves, others, or God in the midst of their crisis. Some Christians may use Jesus Christ as the ultimate model of forgiveness as he constantly forgave others for unjust maltreatment. In *collaborative coping,* both God and the person work to solve the problems together. *Spiritual connection* allows for a person to feel connected to a divine being. *Religious purification* allows for a person to use life circumstances to undergo a transformation, a purification of sorts to reorient themselves away from the destructive paths they believed themselves to be traveling. *Benevolent religious appraisal,* also

called *benevolent religious reframing* occurs when people are able to find solace in stressful situations because they attribute the origin of the situation to the will of God. Those who adhere to this style of religious coping believe that their circumstance is not the result of a punitive God, but rather a loving God who trusts them to handle the situation and who will conform them during their ordeal. With *religious focus* people are able to gain relief from their suffering by focusing more on religion than the stressor itself (Pargament, 1997; Pargament et al., 1998).

Researchers have investigated the various types of adaptive religious coping and have fairly consistently found positive gains from adaptive religious coping. For example, Pieper (2004) found increased psychological well-being and decreased anxiety symptomatology among those using adaptive religious coping (Pieper, 2004). Within the African American community, it appears that collaborative religious coping is a protective factor against feelings of depression and hopelessness, self-destructive and suicidal behaviors, and has been associated with having more reasons to live (Molock et al., 2006).

Maladaptive Religious Coping

Although researchers have found that people are more likely to use adaptive forms of religious coping, it is still important to discuss maladaptive forms of religious coping because it does occur (Bjorck & Thurman, 2007). As Burke et al. (2011) stated, "faith can be a source of strength and a source of contention" (p. 291). Scholars have asserted that people can identify as having a positive relationship with God but at the same time engage in more negative, maladaptive forms of religious coping. For example,

Pulchaski and Romer (2000) proposed that people could be spiritual and yet still be immature in their faith. Such people may be emotionally well but spiritually distressed (Pulchaski & Romer, 2000). While positive religious coping involves people being active and collaborating with God to resolve life crises, more negative, maladaptive religious coping encourages people to defer all action to God and often leads them to blame God as they view God as punitive or absent from their lives (Wachboltz et al., 2007). Exline (2002) suggested that researchers may have neglected the more negative side of religious coping and therefore have solely focused on positive religious benefits but have not thoroughly explored negative consequences that could emerge from misuse of religion and spirituality.

Pargament et al. (1998) identified *spiritual discontent, punishing God's reappraisals, interpersonal religious discontent, demonic appraisal, and reappraisal of God's power* as more maladaptive religious coping methodologies. *Spiritual discontent* occurs when people are mad or displeased with God and the fact that he has allowed the stressful circumstance to occur. This *spiritual discontent* is often not limited to God but can include other congregation members as well, which is also referred to as *interpersonal religious discontent. Demonic appraisal* occurs when people blame the Devil for their stressor. In *reappraisal of God's power*, people redefine God's power in way that would benefit their current situation. For example, people may view their particular life stressor as evidence of God not being in full control of their lives or of the situation (Pargament, 1997; Pargament et al., 1998)

It seems clear that these negative coping strategies tend to produce negative outcomes. For example, researchers found that those who adhere to more negative forms of religious coping were more likely to be depressed (Bjorck & Thurman, 2007; Pargament et al., 1998), less emotionally sensitive to others, and reported a lower level of quality of life (Pargament et al., 1998). When people have a difficult time forgiving God they tend to have a more difficult time forgiving themselves and others, are more likely to be anxious and depressed, and are more likely to question other parts of their religious beliefs (Exline, Yali, & Yobel, 1999). It is important to note that the participants in this study were a convenience sample of students and only 16% identified as African American. It is unclear as to whether these results could apply to all who use religious coping or is specific to Caucasian populations. Juxtaposed against the aforementioned reports about collaborative religious coping, African Americans who used a more self-directed coping style attended church less frequently and tended to be less involved when they did attend (Molock et al., 2006). Additionally, it seems that those adhering to self-directed coping tend to articulate fewer reasons for living (Molock et al., 2006). In addition to these maladaptive coping strategies identified in the literature, other researchers and scholars have identified other forms of maladaptive religious coping, including spiritual bypass.

Spiritual bypass. One of the other maladaptive religious coping styles found in the literature is commonly called *spiritual bypass*. *Spiritual bypass*, also referred to as premature transcendence (Welwood, 2000), is a method of coping in which people avoid confronting emotional pain or past traumas by relying solely on their spirituality. People

who are in spiritual bypass may immerse themselves in spiritual practices or rely on their beliefs and experiences to either explain or avoid uncovering past, painful wounds. They are also likely to avoid actively participating in the therapeutic work that could bring emotional healing. Further, people in spiritual bypass have the capacity to abandon their authentic selves and adopt an alternative identity primarily based on their spiritual identity to avoid dealing with life's disappointments they have likely experienced at some point in their development (Welwood, 2000; Whitfield, 1987, 1991). Someone in spiritual bypass can believe that they have achieved transcendence, which may discourage them from further exploring unresolved issues or past traumatic experiences. Transcendence is a stage in which people are able to connect with a being beyond the physical realm. Many people desire to reach transcendence, but premature transcendence, or spiritual bypass, can be counterproductive and, in fact, stall their spiritual process and development (Young-Eisendrath & Miller, 2000).

Spiritual bypass can manifest itself in potentially problematic behaviors that include spiritual narcissism, spiritual addiction, spiritual materialism, blindly following a spiritual leader without critically thinking for oneself, and abandoning personal responsibility (Booth, 1991; Cashwell, Myers, & Shurts, 2004; Ellis, 2000; Rosenthal, 1987; Welwood, 1984, 2000; West, 2000). Spiritual addicts tend to develop poor personal boundaries, which can hinder their ability to form healthy, long-term relationships with others (Arterburn & Felton, 1991). In a seminal empirical investigation of spiritual bypass, Cashwell, Glosoff, and Hammond (2010) found that one of the symptoms of spiritual bypass, repressed emotions, also called alexithymia, correlated

with symptoms of depression and anxiety. Researchers have found that avoidant coping strategies such as spiritual bypass are also positively correlated with an increased frequency in overeating and smoking (Billings, 1981). It can be difficult for clinicians to assess for spiritual bypass accurately as people currently in spiritual bypass may lack the self-awareness to self-report. Additionally, they are likely to score high on assessment measures of spirituality as they are probably highly connected to their spiritual beliefs and engaged in spiritual practices (Cashwell et al., 2010).

View of God

More than the particular severity of the life circumstance, it seems to be a person's concept of God, their idea of the role God plays in their life, that tends to influence their religious coping styles (Maynard, Gorsuch, & Bjorck, 2001). Maynard et al. (2001) found that those who viewed God as guiding and stable were more likely to adhere to a deferring coping style. Those who endorsed a self-directing coping style were more likely to describe God as benevolent, omni, guiding, and stable. Viewing God as benevolent, stable, and powerful was positively correlated with religious and spiritual importance and religious attendance. Further, researchers found that the self-directing style also was correlated with negative descriptions of God, such as *false* and *worthless*. Moreover, it appears that religious coping is not situation specific. It could be that regardless of the stressor people tend to adhere to their familiar means of coping. It is uncertain how these results would translate to members of the African American community as only 2.3% of the participant sample identified as African American, compared to 68.2% of the sample identifying as Caucasian.

Summary

Although the literature on religious coping seems to be continuously expanding, there remains a need to incorporate other contextual factors that may influence these coping styles. Currently, the existing literature is inundated with quantitative studies. These quantitative methodologies often constrict participants' responses and, therefore, typically produce more concrete results that may, in some cases, miss vital aspects of lived experiences. On the other hand, the inclusion of more qualitative, narrative research methodologies could allow participants to elaborate beyond assessment items, allowing the researcher to gather pertinent, potentially unforeseen data. Further, researchers typically utilize participants who are actively engaged in religious coping and in the midst of a life crisis (Folkman & Moskowitz, 2004), focusing more on the consumer than the provider (Ross, Handal, Clark, & Vander Wal, 2009). Because consumers tend to be immersed in the process, it is likely that they may not be as objective as researchers would prefer (Folkman & Moskowitz, 2004). A study is needed that investigates religious coping but that does so from the perspective of observers and care providers.

A further limitation of much of the existing literature on religious coping is that it is based on studies of predominantly Caucasian participants and is therefore limited in generalizability to other racial and ethnic populations. Moreover, although researchers such as Folkman and Moskowtiz (2004) have suggested that future research should address religious coping by incorporating more contextual variables, little attention has been focused on African American religious coping and the potential influence of African American spiritual leaders.

Because of the salience of religion in many people's identity, it often is crucial and potentially beneficial in stressful times. Researchers must be willing to investigate further, however, how maladaptive religious coping can potentially exasperate these stressors (Oman & Thoresen, 2005; Pieper, 2004) and it must be done so in a manner that is inclusive of various racial and ethnic populations. Further, Wachboltz et al. (2007) challenged future researchers to focus more on the role that social support has in religious coping. Because spiritual leaders often play a critical role in social support for many African Americans, it seems important to investigate how they also influence religious coping in African Americans. Although Pargament et al. (1998) identified *seeking spiritual support from clergy or members* as a form of religious coping, it is unclear whether this would be adaptive or maladaptive coping, especially for population such as African Americans who are typically underrepresented in the religious coping literature. Pargament (1997) added that religious coping is particularly frequent in groups of people who typically possess less power in society. Because of the history of oppression, it is likely that African Americans tend to fit within this classification of a less powerful sub-group who might use religious coping more frequently.

Additional information about African American religious coping could enhance the existing literature and greatly inform the counseling profession. Powell et al. (2003) noted that sometimes religion and spirituality are more of a protective factor rather than a coping mechanism. It is unknown, however, how this translates to a population like African Americans who sometimes view spirituality and religion as a means to survival. Additionally, Bussema and Bussema (2000) found that the majority of people did not get

their sharing needs met by religious coping. However, the participant sample used was primarily Caucasians and it would be interesting to see how this may be different in a sample of African Americans. Moreover, it would be informative to learn more about how spiritual leaders, including African American pastors, view religious coping among their congregation members. Counselor educators, in particular, have a unique ability to influence future counseling professionals, through lectures and scholarly publications, in their ability to appropriately assess and address spirituality and religion (Belcher & Benda, 2005). By devoting increased attention to African American religious coping, counselor educations could sharpen future counselors' skill sets and potentially improve counseling services provided to many African American clients.

Religious Coping in the Black Community

While the experience of spirituality and religion in the African American community has developed over the decades, it remains rooted in African traditions that pre-date slavery (Long, 1997). Not unlike other racial groups, spirituality has served as a source of support for many African American families as they have faced various challenges (Bell-Toliver & Wilkerson, 2011). What may vary for African-Americans, however, are the types of challenges they have had to face as a group of people and the severity of the oppression that has been felt over the years. In fact, Bell-Tolliver and Wilkerson (2011) suggested that given the degrees of opposition many African Americans have had to face and endure, it would be understandable for their psychological conditions to be worse than other groups of people and much worse than they are at this time. Perhaps, spirituality and religion offer some explanation as to why

African Americans are better adjusted and more psychologically well than some experts expect and predict. Many African Americans have relied on their religion and spirituality during difficult life transitions and religious coping often has proven effective in this community (Bell-Toliver & Wilkerson, 2011). Many African Americans have identified God as a core aspect of their coping (Whitley, 2012). Additionally, African Americans assert that attending worship services, attending Bible Study, being involved in their churches, having devotion time, and listening to religious sermons and gospel music allow them to conceptualize their struggles within the larger struggle between good and evil, or God and the devil (Whitley, 2012). In fact, researchers have found that African Americans who attend church more frequently are not as negatively impacted by discrimination (Bell-Toliver & Wilkerson, 2011).

Because of the salience of spirituality and religion in the experience of African Americans, particularly as it relates to their psychological health, it would behoove the counseling profession to increase their knowledge and awareness in this area. Black spirituality and religion has many layers, some of which include more objective measures such as church attendance and others which include more subjective factors such as the direction and support that often is received from fellow parishioners, often referenced as church family (Ellison, Musick, & Henderson, 2008). Two particularly important facets of religion and spirituality and religious coping in the African American community seem to be the Black Church and the pastors who serve as spiritual leaders in this institution (Allen, Davey, & Davey, 2009). Because culture is defined as the way people view the world around them, the Black Church not only influences the culture of many African

Americans but it can also be considered its own unique culture as it likely influences the way its members view religion and spirituality (Eckersley, 2007).

Although both the Black Church and the pastors of this institution have been explored by scholars and researchers, there largely remains a disconnection between the Black Church (and pastors) and the professional mental health community. While some have placed responsibility on pastors to use their influence to increase their members' awareness as it pertains to their health and well-being (Samuels, 2011), it is also the responsibility of the counseling profession to increase knowledge and understanding of the Black Church to more effectively meet the needs of many African American clients they likely will serve (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

The Black Church

The Black Church is the term used in popular culture and scholarly literature that refers to the overall institution that encompasses individual, independently lead local predominately African American Christian congregations. The roles and responsibilities of the Black Church are vast and often include government, finances, education (Byrd 2001), and social justice, just to name a few (Zuckerman et al., 2003). Programs in the Black Church have focused on providing clothing, substance abuse services, tutoring, mentoring, and nonreligious education services (Tsitsos, 2003). Further, many see the psychological health of African Americans as an added responsibility of the Black Church. In fact, the Black Church has been referred to as a psychological therapeutic community, a psychiatric hospital, and a refuge for many African Americans (Douglas & Hopson, 2001; Gilkes, 1980). Historically, African Americans have used the church as a

place to express themselves emotionally, and this expressiveness has, in itself, been seen as a successful therapeutic intervention (Gilkes, 1980). Thus, the Black Church warrants specific attention from counselors and other helping professionals. To understand the Black Church and the people who worship, one must review its theology, history, and explore its developmental process.

Theology of the Black Church. Generally, theology in the Black Church is considered as more of a collective conviction than a representation of an individual's personal belief system (Lincoln, 1970). In other words, theology of the Black Church is seen as the rationale behind many of the Black Church's modes of operation. So to thoroughly understand why the Black Church operates as it does, it is imperative to understand the theology. Theology unites the Black Church but also differentiates local congregations. That is, the Black Church often is misconstrued as being a homogenous grouping of individual churches but differences in theology make this a false pretense (Barber, 2011). Often, individual black churches and denominations vary in theological principles and, therefore, differ in how they execute beliefs about their purpose, roles, and responsibilities (Barber, 2011; Lincoln, 1970).

Most Black churches unite in the theological belief that during worship services they experience a personal visitation from Jesus. This theological notion guides the way services are typically conducted. The aforementioned visitation could be manifested through rituals and practices such as "shouting", singing gospel songs and hymns, or speaking in tongues. To that end, Moore (2003) noted these as examples of the liberal and animated worship that often is indicative of the Black Church. Additionally, other

practices that are common to the Black Church and reflective of its theology may seem befuddling to those unfamiliar with these practices. Often, the Black Church may be more likely to reference God and Jesus interchangeably. In spiritual practices, such as prayer, Blacks may use God and Jesus synonymously, which could be confusing to some outside observers and investigators (Johnson, 2010).

Because of these complexities, the Black Church can seem confusing to observers who are not immersed in the culture. Moreover, questions about the variations in theology and the often ambivalent character of an institution that can be so progressive yet so rooted in tradition and bound to theology have given some pause for concern (Douglas & Hopson, 2001). For researchers interested in understanding the Black Church, and for that matter the African American community in general, it is likely that the religious theology that guides the Black Church and many individual parishioners can provide helpful insight.

Liberation theology. James Cone's liberation theology is one of the most prevailing schools of thought in the Black Church (McBeth, 1981). According to liberation theology, Black Americans were able to take Christianity, traditionally perceived as a White man's religion, and adapt it to plights and triumphs of African Americans in the United States. Compared to other theologies, liberation theology is seen as a comprehensive theology because it considers how individuals view God and how they interact with each other. Accordingly, the relationship between church members is informed by liberation theology (McBeth, 1981). Because the master and slave relationship was seen as the epitome of evil, Blacks put a significant emphasis on

forming and preserving healthy relationships (Burrow, Jr., 1994; Douglas & Hopson, 2001).

According to liberation theology, the Black Church offered oppressed Blacks a sense of freedom rarely experienced in their personal and professional lives. Not only was the Black Church seen as a place where Blacks could gather to vent their problems, but it was also a place where change could be created and enacted. Cone argued that this was the true role of the church, to promote this freedom, and churches that neglected this responsibility were ultimately abandoning their true purpose (McBeth, 1981). While other theologies focus on Whites as oppressors, churches who ascribe liberation theology tend to focus less on the oppression and more on the freedom that is felt when congregation members' fellowship with one another (Burrow, 1994).

Further, the importance of addressing people holistically, emphasizing the connection of the body and the mind, is rooted in liberation theology (Burrow, 1994). In this regard, it appears that the spiritually founded liberation theology of the church and the medically founded bio-psycho-social-spiritual model may complement one another well. Leaders of the Black Church may not automatically articulate views using language of the bio-psycho-social-spiritual but they may be able to do so using language of liberation of theology. Thus, it is incumbent upon researchers to build connections and probe deeper in Black religious theology and counseling models.

"Alternate society" theology. E. Franklin Frazier's idea of the alternate society is somewhat similar to liberation theology. In this theology, Frazier proposed that the Black Church should operate as a sovereign society where Blacks would be able to fully express

their authentic selves (McBeth, 1981). This theology was founded upon Frazier's belief that Whites did not understand Blacks and, therefore, could not adequately meet their needs (Frazier, 1963). Frazier endorsed the idea that the Black Church would be a separate nation within the United States and would meet the needs of the Black community in ways beyond just the spiritual. Optimally, the Black Church would be able to produce education centers, financial institutions, housing, and provide ample social outlets (C. E. Lincoln & Mamiya, 1990). Ironically, Frazier acknowledged that this alternate society would further inhibit Blacks from successfully acculturating in the majority culture in which they were expected to live and function (Frazier, 1963). It is likely that churches that ascribe to this theology will believe that they will be able to meet psychological needs of their congregation members. In fact, in churches where this philosophy is predominant, it is possible that members who seek guidance from pastors may be discouraged from receiving services outside of the Black Church.

"Joseph" theology. Scholar Carter G. Woodson introduced idea of the *Joseph Image* as a theological stance. This theology uses the biblical prophet Joseph and his story as a parallel to the history of African Americans. According to the Old Testament, Joseph's own brothers sold him into slavery because of extreme jealousy. Instead of rebelling and becoming bitter, however, Joseph maintained a positive attitude and in the end was rewarded and promoted because of his humility and character. In other words, while Joseph would have been justified in his indignation, it may not have produced the same results for him. According to Woodson's theology, if the Black Church and the African American community assume the characteristics of Joseph, rather than more

militant approaches, to respond to incidents of oppression and discrimination, they too would be vindicated in the end. Woodson proposed that, like Joseph, Blacks would ultimately be promoted as well (McBeth, 1981).

"Other worldly" and "this worldly" theology. *Other worldly* churches are those that believe in deferring freedom and reward until after death. In other words, these churches are more accepting of present pain and suffering as they believe they will experience relief when they die and get to Heaven. Spiritual songs that were birthed to comfort, direct, and relieve Black slaves have become a critical part of *other worldly* theology. These songs serve as a reminder that earthly suffering is only temporal and an eternal promise of heavenly peace awaits them upon death (Wiggins, 2011). Preachers are also an important mouthpiece for *other worldly* theology. During slavery, preachers often delivered sermonic reminders of the life that would come after death, one that was contrasted with their current reality of enslavement. Today, although some of the challenges may be different, preachers may continue to uphold messages of enduring present suffering and awaiting the promises that accompany death (Wilmore, 2006).

On the other hand, *this worldly* churches typically explicitly advocate for Blacks to experience earthly freedom and happiness. For example, whereas a member of an *other-worldly* church may be satisfied with receiving physical healing through death, a member of a *this-worldly* church may pursue avenues, like medical options, to achieve this healing on earth without having to die. In fact, they will likely to do what they can to avoid death (C. E. Lincoln & Mamiya, 1990).

Priestly and prophetic theology. Another method to distinguish local, independent black churches within the larger Black Church institution is along the *priestly* and *prophetic* paradigm (C. E. Lincoln & Mamiya, 1990). The *prophetic* theology arose from Biblical prophets, such as Isaiah, who were instructed by God to challenge injustices imposed on the people of God by secular government officials. These stories are particularly appealing to African Americans who may identify with living under oppression (S. K. Roberts, 2003).

Alternatively, *priestly* churches tend to expend their energy on ensuring that Sunday morning worship experiences are efficacious (C. E. Lincoln & Mamiya, 1990). This success could possibly be measured by whether they feel they experienced a visitation from Jesus. *Priestly* churches maintain that providing opportunity for Blacks to worship freely is equally beneficial as *prophetic* churches that tend to directly intervene in other areas of the members' lives (C. E. Lincoln & Mamiya, 1990; Starling, 1999).

Interestingly, many of the most widely known leaders of the Black church were *prophetic* in their approach as they assumed the position that the Church's role extended beyond creating memorable worship services on Sunday morning (Starling, 1999). With that, the Black Church and its local entities continue to attempt to navigate their position in mainstream American culture (Gadzekpo, 1997). Further, pastors are also likely attempting to navigate how they will approach their positions and carry out their *prophetic* and *priestly* roles. This has implications as to which theology they ascribe and this likely will drive how they serve the needs of their congregation members. Counseling professionals should familiarize themselves with the theological language of the Black

Church and, more locally, the theological presumptions of Black preachers in their community as this likely influences how many African Americans respond to emotional struggles.

Folk religion theology. While most theologies painted the Black Church in a positive light, through the idea of *folk religion,* Joseph R. Washington implied that the Black Church was a platform to popularize superstitious beliefs and remnants of traditional African religious practices and rituals (McBeth, 1981). For example, Washington was especially critical of gospel music, referring to it as "degenerate" and an unacceptable part of Black worship experience (C. E. Lincoln & Mamiya 1990; Washington, 1964). Some scholars saw this viewpoint as demeaning and insulting to African traditions and the intellect of Blacks (McBeth, 1981).

Historical development of the Black Church. Understanding the current relevance of the Black Church requires an understanding of its role and relevance over the years. Just as the African American community has changed, progressed, faced different challenges, struggled, and exhibited great resilience, so has the Black Church. Often, the Black Church as an institution has faced these challenges alongside African Americans as individuals. Much of the literature traces the origins of the Black Church back to the days of slavery.

The Black Church and slavery. During the years of slavery, many plantations had a general rule forbidding more than five slaves to gather at a time without supervision. Acceptable supervision meant that a White man had to oversee the gatherings. This statute stifled slaves' sense of community and opportunities for

fellowship on plantations. Although slaves possessed a desire for religious and spiritual expression, this rule complicated their ability to assemble for worship services. Instead of abandoning this need and in fear of repercussions from breaking the rule, slaves resorted to informal worship gatherings in secret locations that included swamps and wooded areas (Frazier, 1963; C. E. Lincoln, 1973). Gospel songs composed and often sang at these gatherings were used to communicate secret messages between slaves of hope, freedom, and endurance (C. E. Lincoln, 1973). Eventually, during the mid-1700s, these informal gatherings became less secretive and more visible (Pinn, 2011), laying the foundation for the institution that would be later referred to as the Black Church. The churches were the epicenter of the slaves' community and provided the fellowship that slaves lacked elsewhere on the plantation. Also, it was through the church that many slaves were educated, learning to read using Biblical scriptures (Wilmore, 2006).

The scriptures that slaves learned to read provided emotional relief and hope of a promising future void of the oppression they were experiencing. During this time, the theology that would be later termed *other-worldly* was birthed as slaves looked forward to death as a transition from suffering on Earth to a promise of reward and deliverance in Heaven (Johnston, 1954; Wilmore, 2006). Plantation owners became afraid that if slaves were able to read the entire Bible, their proclivity to defer hopes of freedom until after death would minimize and a surge of strength and demand for emancipation would emerge. Slave masters were frightened that slaves would acquire knowledge of the whole council scripture that would illuminate the flaws and biblical inconsistencies of a despotic slave system. With a comprehensive knowledge of scripture, the slaves would have an

increasingly difficult time reconciling a biblically based system that would capture and enslave innocent people (Taylor et al., 1987). The fears of many slave owners were realized as slaves became discontent with their present situations and used the church as a means to bring about change.

As slaves' knowledge grew, so did their frustration with organized religion, particularly Christianity, as it was seen as another vehicle used by Whites to advance oppression (C. E. Lincoln & Mamiya, 1990). Black slaves could especially relate to the persecution and torment of Jesus Christ, the pivotal figure of Christianity. In fact, slaves even likened the crucifixion experienced by Christ to the popularized practice of lynching Black men (Pinn, 2010; Terrell, 1998). Terrell (1998) further elaborated that the connection with Jesus and slaves also was related to the Bible story of Judas betraying Jesus for economic compensation. The slaves felt they were also betrayed, captured, and brought to America for the economic gains of others, particularly that of the White plantation owners (Pinn 2011; Terrell, 1998).

In essence, it was the feeling of discrimination and racism that ignited a desire for Blacks to create separate structures for worship and eventually develop into the institution that would be known as the Black Church (C. E. Lincoln, 1973). Black churches were incepted out of a desire of Black slaves to have their own worship places on Southern plantations. Their churches were the place they felt that they could be themselves and where their status as a slave did not consume their identity. These services provided an emotional relief for many slaves, a departure from the pressures and brutality experienced on the plantation (Wilmore, 2006). Many of these Black churches

also doubled as stops along the Underground Railroad to assist slaves to freedom by navigating them safely to northern states and Canada (Johnston, 1954).

Richard Allen inaugurated the first black church of the Methodist denomination in 1807 (Wilmore, 2006). The formation of the Black Methodist churches was considered a visceral response to the Methodist tradition of having segregated churches for Blacks and Whites. Even when Blacks were allowed to worship in the same buildings as Whites, Blacks felt that they were treated poorly. Instead of church being a sacred haven away from maltreatment, it was another opportunity for Whites to exert their power. This became overwhelming for many Blacks. This departure of Blacks from the Methodist church because of inequality was one of the first major civil rights protests from African Americans (C. E. Lincoln & Malaya, 1990). Subsequently, other predominately Black congregations of Baptist, Presbyterian, and Episcopal denominations also were formed (Dubois, 1903) setting the stage for the prominent emergence of the Black Church during the civil rights era.

The Black Church and the civil rights era. During the 1950s and 1960s, the Black Church became increasingly more autonomous as it began expanding its own doctrinal beliefs, electing its own leaders, and even creating seminary institutions where these leaders could be educated (C. E. Lincoln, 1973). Further, the Black church offered a platform for activists and provided financial support to organizations such as the National Association for the Advancement of Colored People (NAACP) to help promote messages of equal rights for African Americans (Chandler, 2010). The Black Church worked at both the macro and micro levels of society. For example, on the macro level large

institutions such as the NAACP could garner support from the Black Church, and on the more micro level individuals having difficulty fulfilling financial obligations could also receive economic assistance. This growing financial independence initiated the self-help doctrine, as Blacks could not rely on support from outside sources. Blacks were taught that in order to survive they had to support themselves financially, mentally, emotionally, and socially (Littlefield, 2005).

Arguably, Dr. Martin Luther King, Jr. is the quintessential symbol for the power the Black Church possesses to create and influence change on a larger landscape (C. E. Lincoln, 1973). Dr. King is thought of as one of the most influential leaders in American history; however, scholars argue that in order to truly understand Dr. King one must understand the Black Church and explore his role as a pastor (Erskine, 1991). Contrary to other historical church and civil rights leaders such as Nat Turner, also a minister, Dr. King took a non-violent approach to bringing about desired change and equality. Similar to the "Joseph" theology, the non-violent approach seemed to be producing favorable results for African Americans as they began gaining more equitable access in mainstream culture. Yet, some were opposed to this peaceful and seemingly passive approach. In fact, at times the NAACP was accused by some of being too "polite" in their fight against injustice. Some called for a return to leadership like Nat Turner, a more visceral and militant approach, during the fight for emancipation (Wilmore, 2006).

The Black Church became a political platform for Blacks because they had limited access to political activities in their communities, states, and in the nation (Erskine, 1991). Like Frazier's idea of an alternate society, many Black churches saw

themselves as their own governmental entities, electing leaders. Soon, the Black Church began to formally endorse particular candidates who seemed to support their agenda of achieving equal rights. This practice has carried into today's society by some churches who are still very politically active and overt in their support for particular political candidates and parties (Barber, 2011). Particularly during the Civil Rights Era, the Black Church was a place that Blacks could experience prestige, rank, and authority that was otherwise denied to them by outside institutions, typically dominated by the majority culture (Douglas & Hopson, 2001).

The Black Church of the 21st century. The Black Church has changed over the years and many would have not predicted where it would be today. Watson et al. (2003) identified Black mega churches as today's most visible image of the Black Church to the general public. In 1995, the largest predominately Black mega-church claimed 18, 000 members. Today, The Potter's House, led by Bishop T. D. Jakes, one of the largest Black mega-churches in the country, has over 30, 000 members. With the rise of the Black mega-church also came the rise of neo-Pentecostalism. Neo-Pentecostalism has been described as a more enlightened and educated version of traditional Pentecostalism that still embodies the expressive elements of worship (Barber, 2011). It is likely that this brand of worship appeals to progressive, often highly educated Blacks of the 21st century who still value traditional elements of Black worship. Today, some argue that the rise of mega-churches has made the Black Church more commercialized. The expressive spiritual practices and rituals that founded the Church are now considered by some as a way to quickly rise to fame and attain financial gain (Johnson, 2010).

While the Black church of past decades may have focused on achieving equal rights in the community, today's Black Church faces its own set of challenges. Some of these challenges include physical illnesses such as HIV/AIDS and social issues such as welfare reform and disproportionally high unemployment rates of African Americans (Billingsley, 1999). Nonetheless, Blacks have certainly made considerable strides in advancement compared to previous decades, particularly in the areas of education. Many argue that these strides should be attributed, at least in large part, to the efforts of the Black Church (Byrd, 2001). Although these new challenges may seem daunting for the Black community and the Black Church in particular, scholars encourage the Black Church to draw on the strength that has brought it through turbulent times such as slavery and the Civil Rights era (Billingsley, 1999). The Black Church is an institution of both strength and imperfections, but even with its imperfections people become invested in the institution and it becomes part of their identity (McRae, Carey, & Anderson-Scott, 1998). C. E. Lincoln (1973), who was both a respected scholar in academia and an avid member of the Black Church, stated that in order for the Black Church to retain its vitality in the future, it must be resolved in delaying instant gratification and adopt a stance that will effect long term change (Billingsley, 1999; C. E. Lincoln, 1973). This is particularly important as the African American community faces issues such as disproportionate physical illness, financial strains, anxiety, depression, and other familial issues that will likely not be eradicated overnight. Further, scholars have suggested that ways to resolve these issues include tapping into the influence of the pastors of the Black Church as it once did with figures like Dr. King (Watson et al., 2003).

Pastors in the Black Church. Historically, African Americans owe much of the growth they have enjoyed to the efforts of leaders in the Black Church. The influence and power afforded to Black preachers of more modern times is a stark contrast to the period of slavery when it was illegal for Blacks to preach in North Carolina (C. E. Lincoln, 1973). From their pulpits, Black preachers have an inherent platform to disseminate their attitudes and many times these attitudes and beliefs are embedded in sermons delivered weekly to a waiting congregation of followers (Watson et al., 2003).

Black preachers are so influential and representative of the Black community that their professional and personal shortcomings often are broadcast publicly (Pinn, 2010) and words spoken from the pulpit can grant notoriety or make preachers infamous. Sometimes this pulpit comes under scrutiny, as was the case with Reverend Jeremiah Wright during the presidential campaign of then candidate Barack Obama. Interestingly, in 1993 *Ebony Magazine* had identified Rev. Jeremiah Wright as the second greatest Black preacher in America (Billingsley, 1999); however, Rev. Wright's public image was stricken when the world became fixated on his sermons and to many his words were considered inflammatory, hate-driven, divisive, and anti-American (Bell, 2009).

Even with their impact and influence, one of the limitations Black pastors may experience is their inability to provide for the community as they would like because of limited availability of resources, particularly economic resources. While the self sufficiency of the Black Church has been one of its greatest strengths, it is also difficult as African Americans are often the ones most economically affected during financial crises, impacting their ability to contribute to their churches (S. K. Roberts, 2003). So,

while pastors are expected to respond to numerous challenges facing the Black Community, often they are inhibited because of the lack of financial capital. The question then arises as to how these limitations could impede pastors' ability to provide services, such as mental health support to parishioners.

African American pastors and mental health. One area in which African American pastors find themselves involved is in the mental health needs of their congregation members. In fact, one account suggests that over one-third of African Americans who have experienced personal concerns have sought help from clergy (Veroff, Douvan, & Kulka, 1981). J. L. Young, Griffith, and Williams (2003) found that clergy have provided services to members facing substance abuse issues, difficulties with adolescents, unemployment, relationship issues, and grief. In fact, individuals who receive some sort of support and assistance from clergy about depression, health, death, and emotional issues appear less likely to seek out additional sources for these issues (Neighbors et al., 1998). When addressing these issues, pastors respond by listening, invoking spiritual practices, and referring to outside mental health services (J. L. Young et al., 2003). Pastors have apparently embraced this aspect of their occupation as researchers have found one of the roles most identified with and valued by pastors is the counseling role (Moore, 2003). Some African American churches have developed ministries devoted entirely to the mental health needs of their congregation. Typically, these ministries are primarily biblically based, but in some models mental health professionals provide the majority of the services (Ennis, Ennis, Durodoye, Ennis-Cole, & Bolden, 2004). These types of ministries are not available for all African Americans,

which could mean that African Americans seeking help from their spiritual leaders receive various responses, level of care, and guidance. Overall, it seems that African Americans who sought help from clergy were more satisfied than others who sought help in more formal, clinical settings (i.e. counseling; Neighbors et al., 1998).

These various services could be representative of differing pastoral beliefs, values, and messages communicated. Some African Americans have received messages from pastors and fellow congregation members that their struggles achieving mental health are due to a spiritual deficit within themselves (Newhill & Harris, 2007). For example, Payne (2008) used qualitative interpretative analysis to review transcriptions of sermons in which messages about depression and mental health were communicated. In the study of exclusively Pentecostal preachers, both men and women, Payne found that the terms "mental health", "mental illness" or "depression" were not frequently used, however; terms such as "crazy" and "attitude" were used to describe people dealing with mental health issues. From these sermons, it appears that Pentecostal preachers conveyed negative messages about psychotropic medications and professional mental health care providers and insinuated that relying on Jesus would negate any emotional struggles. Some preachers even stated that there was something inferior about Christians who were experiencing these symptoms of depression (Payne, 2008).

African American parishioners may desire to seek help from their spiritual leaders and outside services, but their pastors' perspectives on these issues may heavily influence their final choices. Because African Americans identify the pastoral love as one of the greatest benefits of being involved in a religious community, they could be more likely to

follow a pastor's direction and guidance without critically thinking on their own and choose to not seek services for fear of offending their leader (Chaney, 2008).

Pastors' beliefs about the etiology of psychological stressors could also be telling as to why African Americans are less likely to seek treatment and why, if they do seek treatment from their spiritual leader first, they are not as likely to pursue other resources. Payne (2009) reported that African American pastors were more likely than Caucasian pastors to identify depression with hopelessness and a lack of trust in God. Although the researcher was intentional about deriving differences between Caucasian and African American pastors because of the quantitative methodology, the pastors were not given the opportunity to elaborate on these statements, rather responded to pre-constructed survey items. Accordingly, little is known about the experiences, beliefs, and attitudes that underlie these different perspectives. Kramer et al. (2007) found that ministers identified depression as a primary concern for members of their congregation and the researchers conducted focus groups to gain information about etiology and procedures for care. While ministers were asked to talk about their perspectives within the framework of bio-psycho-social model, the researchers did not ask the ministers to apportion their beliefs about the etiology for each domain. For example, if pastors believe that depression is a combination of biological and spiritual, what percentage do they attribute to each? Although African American pastors and Caucasian pastors were in separate focus groups, the researchers provided scant attention to racial differences. Moreover, although the researchers used a qualitative approach, the focus groups did not allow for each pastor to go into detail, as would individual interviews. Further, scholars who do focus on the

pastoral counseling role and etiology beliefs tend to focus primarily on depression (Kramer et al., 2007). While depression clearly is one focal point of counseling and, indeed, an important one, researchers may be neglecting other issues such as anxiety, which is also salient for many African Americans as they are facing issues like unemployment at disproportionate rates, and bereavement, salient because of losses experienced within the Black community (Laurie & Neimeyer, 2008).

Also, pastors may feel that they have to compensate for lack of attention to spiritual needs by mental health practitioners, which in turn may lead to an overcompensation and overemphasis on the spiritual component (Oppenheimer, Flannerlly, & Weaver, 2004). Because of this, it is important that counseling researchers and practitioners make connections to leaders in the Black religious community and learn more about the Black church in order to better serve many African American clients. Moreover, it is imperative that counselors are aware of pastors' attitudes and beliefs as they likely influence the beliefs and attitudes of their congregation members as well (Allen et al., 2009).

Researchers have paid limited attention to the pastoral counseling role in the Black Church. For example, J. L. Young et al. (2003) interviewed pastors and elicited information pertaining to the method in which pastors delivered counseling, the issues they typically saw from parishioners, and how frequently they made referrals to outside mental health agencies. While this study provides a foundation for future research in this area, what remains unknown is more about the pastor's attitudes and beliefs. For example, more information is needed on what informs pastors' decision to refer to

outside agencies, their personal history with mental health issues, their beliefs about adaptive and maladaptive coping, and specific examples from their experiences. Other studies have focused exclusively on the modes of operation of churches with counseling programs that seem to be effective in meeting the needs of their congregation and which have been replicated at other churches (Ennis et al., 2004). Again, these studies are lacking more information about the pastors' attitudes and beliefs that may help explain how and why these churches developed in this particular manner. Additional research could inform the counseling profession on the details of this interaction and why African Americans tend not to pursue additional treatment after going to their pastor first. This is particularly salient as Black people who have experienced severe psychological problems such as "nervous breakdowns" are most likely to seek support from their ministers and likely do not receive services such as therapeutic interventions and prescription drugs that they could receive if they saw a counselor or psychiatrist (Neighbors et al., 1998).

As to whether African American pastors are a "bridge" or "barrier" for African Americans seeking help for mental health issues, Neighbors et al. (1998) found that African Americans seek help from their pastors, are satisfied with the help they receive, would refer other people to see their clergy, and are unlikely to pursue other services. Although this is useful information, it provides another illustration of the focus on the "what" of the relationship between the Black Church and mental health and not the "why". That is, researchers clearly have focused their efforts on understanding the process through which Black parishioners tend to go when faced with mental health issues, but have not explored the mechanisms (such as experiences, beliefs, and attitudes)

that undergird these processes. The primary function of this study, then, is to turn attention toward these underlying mechanisms and to more fully explore the "why" questions related to the influence of Black pastors on mental-health help-seeking behavior.

Summary

Theologically, the Black Church seems to be comprised of core beliefs, those beliefs that seem to be central and fundamental to the Black Church, and contingent values, those that vary across congregations and denominations (Douglas & Hopson, 2001), many of which are promoted by pastoral leaders in the Black Church. In order to truly understand the theological underpinnings and core and contingent values of the Black church, researchers must go beyond common literary approaches. Traditionally, researchers have focused on the Black Church by presenting historical accounts. Now, researchers must transition to a methodological approach that intentionally investigates the many components of the Black Church (Johnson, 2010). Often, researchers have referenced the Black Church as open and responsive to the population they serve (Ennis et al., 2004); however, it is possible that this openness and responsiveness may be varied among individual congregations. A more balanced approach will not only give an account of historical influences but it also will yield new information as well. With that, researchers must be prepared to report both assets and imperfections that exist within the Black Church.

The Bio-Psycho-Social Model

In the mid-1970s, Dr. George Engel, a medical physician, began to question the relevance and effectiveness of patient treatment that was primarily based on the traditional medical model at that time. This criticism culminated with a seminal article and proposition for a new way of helping people. Engel (1977) proposed the bio-psycho-social as a more comprehensive and effective approach to assessment and treatment (Engel, 1977). Engel suggested that the lack of effectiveness with the current model began with the physicians' perception of disease. In fact, Engel had become displeased with the definition of disease as a "deviation from the norm of measurable biological (somatic) variables" (Engel, 1977, p.130) because he believed that this allowed physicians to treat patients without consideration for the psychological and social aspects of their lives. In response to his disillusion with the medical model, Engel suggested the bio-psycho-social model as a way to both analyze the illness and consider more holistically the person who is suffering. Some researchers have referred to the model as a treatment approach that is an even more heightened form of "patient centered" care (Margalit, Glick, Benbassat, & Cohen, 2004). Even as he introduced this new approach, he also reminded readers that the purpose of a model is for people to organize their thoughts and beliefs about phenomena that is particularly complex or disturbing (Engel, 1977). Scholars have noted that Engel's contributions allow the subjective information about a client, like their cultural and social history, to be considered objective and not merely dismissed as irrelevant or insignificant (Suchman, 2005). In fact, Engel considered it the provider's to include a patient's contextual factors (Engel, 1977).

Because of Engel's background in medicine, the original intended helping relationship of bio-psycho-social medicine was between a medical physician and their identified patient (Landau, Layman, Levinson, & Waite, 2003) with the responsibility of determining etiology belonging to the physician (Engel, 1977; Landau et al., 2003). Although Engel did not intentionally create the bio-psycho-social model to be used by mental health professionals, he believed that it could be adapted to apply to one's mental as well as physical health, even noting the proclivity of many medical professionals to minimize the significance of psychological factors in many medical conditions (Ghaemi, 2009; McLaren1998). It appears that the bio-psycho-social approach is a way to provide cost-effective services to consumers that does not require a longer duration of treatment; further, physicians who received training in the bio-psycho-social approach were less likely to prescribe medications for patients (Margalit et al., 2004).

Historically, mental health clinicians have assessed health and illness from four different paradigms, which include formistic, mechanistic, contextual, and organistic (Schartwz, 1982). Formistic and mechanistic paradigms tend to be more dualistic in that clinicians who take this approach try to compartmentalize symptomology and are likely to attribute mental illness to a specific cause similar to positivism, which emphasizes what is observable and measureable (Galanter, 2010). For example, from this perspective, a physician will likely tell a patient who presents with a headache to undergo cat scans to find the source of the pain. On the other hand, a contextual paradigm indicates that no presentation, sickness or health, occurs in isolation and suffering or illness does not merely affect the identified client but each relationship in their life. Organistic clinicians

are likely to attribute mental illness to a combination of multiple events that could include biological factors but other circumstances, including familial issues, are not excluded. It is likely that an organistic clinician will likely consider that the patient who presented with headaches has recently ended a ten year intimate relationship as a possible contributing factor. Engel himself criticized clinicians for taking a dualistic approach exclusively isolating illness solely to the person who presents in their office. Moreover, he suggested that prior to the introduction of the bio-psycho-social model, many physicians approached the mind-body connection in a dualistic manner, disregarding the bi-directional effects, choosing instead to focus on them as separate entities (Engel, 1978). Instead, he proposed addressing other variables, and even people, that may be contributing to the patient's current situation and who could also be a part of the solution (Borrell-Carrio, Suchman, & Epstein, 2004). Thus, the bio-psycho-social model is most like the organistic perspective.

Whereas other medical paradigms, like the biomedical model, are more pathological in nature, the bio-psycho-social model is unique because of its strength based foundation. The presence of current pain or discomfort, mental or physical, is not necessarily indicative of a deficit or inadequacy in the person (Lindau, Laumann, Levinson, & Waite, 2003) and even the lines between being well and ill are not as clearly defined when you consider the influence of one's social or cultural environment (Engel, 1977). The bio-psycho-social model does not merely focus on how people are sick but also how they are well. In fact, some scholars suggest that the bio-psycho-social model is a preventative approach and can promote health over illness, and remove blame from the

individual, potentially reducing shame in seeking help (Lindau et al., 2003; Shorter, 2002).

Application of the Bio-Psycho-Social Model

Alladin (2009) argued that the true measure of the usefulness of a model is how it can be applied. Engel seems to have set a high standard for application of the bio-psycho-social model (Westerman, 2007). With this high expectation, it appears that some scholars have lambasted Engel for not adequately equipping practitioners and researchers with enough information and instruction on how to appropriately integrate the model in their clinical work. Without this information, the model cannot be applied effectively (Westerman, 2007). Other scholars have suggested that a health professional specifically trained in one area cannot competently assess the various domains of the bio-psycho-social model. For example, it may be difficult for a mental health counselor trained primarily from a clinical perspective to appropriately assess biological factors possibly contributing to a client's presentation (McLaren, 1998). However, Engel (1977) challenged providers to be competent in each domain of the model. Additionally, some clinicians are hesitant to utilize the bio-psycho-social model because they fear that that the holistic approach may minimize the importance of the biological perspective. Others acknowledge the risk that exists in considering all factors in that they may miss the most significant cause and, thus, the best avenue for cure (Borrell-Carrio et al., 2004; Shorter, 2002). This comprehensive approach may leave clinicians feeling confused about where to focus the initial phase of treatment (Ghaemi, 2009). Moreover, because Engel's focus was primarily on assessment, there is not much explicit direction on treatment

recommendations after one considers all the different elements contributing to the present state (Epstein & Borrell-Carrio, 2005). Some researchers have suggested that the bio-psycho-social model may be particularly applicable for some specific populations. For example, Berzoff (2011) proposed that the bio-psycho-social is well suited for populations who may be vulnerable, considered "at-risk", or have experienced some form of oppression. In the case of African American men and women, this model has been used to help understand coping strategies for racism. By considering racism through a bio-psycho-social lens, clinicians are able to see more clearly how racism may be affecting African Americans biologically, psychologically, and socially (Clark et al., 1999). Alladin (2009) took this idea a step further and added ethnicity as an additional factor to the model, stating that a truly relevant model is one that considers an individual's culture and subsequent human rights. Similarly, the bio-psycho-social model has been applied to working with older adults and those who are struggling with chronic illness (Cohen & Koenig, 2003).

Challenges of the Bio-Psycho-Social Model

Even with all of this support and perceived positives, the bio-psycho-social model is not without reproach and criticism. Although groundbreaking at the time of its inception (McLaren, 1998) and relatively strong as an approach (Westerman, 2007), the bio-psycho-social model is not immune to imperfections (McLaren, 1998). Scholars have argued the difficulty of teaching and applying the model (David & Holloway, 2005) and the need for more direction in how to do so (Suchman, 2005). Moreover, Some scholars argue that the model has become outdated and has lost its relevance in current society

(Ghaemi, 2009; Shorter, 2002). That is, some argue that while the bio-psycho-social model was a progressive proxy for the traditional medical deficit based model when it was introduced in the 1970s, its appropriateness should be reassessed for use in today's society (Ghaemi). Others argue that in some ways the bio-psycho-social model has become a more simplistic way of thinking about a client and does not consider the biological discoveries and advances with pharmacology that have come over the years since the model was first introduced and promoted by Engel (Shorter, 2002).

One of the greatest challenges in applying the bio-psycho-social model is the difficulty in testing it empirically. In fact, this may be the primary factor that has impeded the clinical impact of the model (Schubert, 2010). Researchers find it difficult to measure multiple dimensions simultaneously (Schwartz, 1982; Suls & Rothman, 2004). Moreover, additional research needs to be conducted about the effectiveness of assessment and informing treatment recommendations. Treatment recommendations can be difficult to implement as the biological and psychological treatments may not complement each other as easily as one would like (Schwartz, 1982).

The Addition of the Spiritual Domain

Perhaps one of Engel's most significant oversights was not including spirituality as a specific, separate domain in the model as it is often overlooked in many bio-psycho-social models and assessments (O'Reilly, 2004). Cairns (2011) noted that spirituality is not a variable to be considered in isolation, apart from social, biological, and psychological factors. Rather, it is compatible with the bio-psycho-social model and thus warrants a place in the model. In fact, Puchalsky and Romer (2000) argued that

spirituality is what connects the different dimensions and, as such, its exclusion could be limiting one's ability to comprehensively assess and treat the client. Thus, the bio-psycho-social-spiritual model assumes that each person has a spiritual background that affects his or her current presentation in some way. This history may or may not include a particular religious affiliation. Either way, consideration of the spiritual dimension is important to consider in diagnosis, treatment, and recovery (Sulmasy, 2002). Additionally, researchers have consistently found that religion and spirituality directly affect the other factors of the model by improving the social, psychological, and biological lives of people (Ackerman et al., 2009) and integral in their recovery from various psychological illnesses (Galanter, 2010).

Summary

There is a scarcity of literature that links the bio-psycho-social-spiritual model to pastoral beliefs about mental illness and none that have focused exclusively on African Americans pastors in an empirical investigation. Farris (2006) comprised a literature review that used the bio-psycho-social model and a spiritual model as a framework for the role of pastors in mental health care, but did so as two separate models. In a separate empirical study, Kramer et al. (2007) asked pastors to talk about their beliefs about depression according to biological, psychological, social, and spiritual factors. However, this study did not exclusively focus on African American pastors and did not interview the pastors individually. These individual studies need to expanded in a manner in which the bio-psycho-social model includes the spiritual component as one comprehensive framework that specifically explores African American pastors' beliefs and roles

concerning the mental health issues and coping mechanisms of their congregation members.

As the counseling profession moves toward a more evidence-based treatment practice, it is vital that the counseling profession incorporate the perspective of African American spiritual leaders. More empirical research is needed that explores dimensions of biological, psychological, social, and spiritual aspects of issues such as anxiety, depression, relationship problems, and unemployment, particularly in African American communities where these issues are especially salient. It is imperative that counselors seek out the voices of African American spiritual leaders as doing so may increase understanding of current help seeking behaviors, gain more information about current treatment being received outside of more formal clinical sessions and potentially improve the profession's ability to provide more effective treatment to a population that has been traditionally underserved and in some cases whose voices have remained unheard. As a participant in Kramer at al. (2007) stated:

> I think there has to be a healthy balance, and I think that even the other side of those that might be in mental health might say, "Well it's strictly a mental health issue. It's strictly a social issue. It's strictly a psychological issue. Faith has nothing to do with it." Well you know, studies can go both ways, and it has been proven that those who have some semblance of some kind of faith generally fare better than those who have no faith at all. So, trying to bridge the gap, you know, for me is difficult. (p. 128)

The current study will help supplement the existing literature by chronicling and organizing the perspectives of Black pastors and doing so in a manner which allows new themes and information to emerge.

CHAPTER III

METHODOLOGY

> The search for possible mediators of relationships between religious and spiritual factors and health indicators deserves top priority at this time. Other studies are important, but identifying mediators holds special promise to accelerate and advance our understanding. (Oman & Thoresen, 2005, p. 454)

Overview

The purpose of this chapter is to explain the research methodology used in this study. In this chapter, research questions will be restated and the procedures of Consensual Qualitative Research explained. This chapter will conclude with a report of the pilot study and the modifications made to the full study as a result of the pilot study process.

Research Questions

The research questions were initially introduced in Chapter 1 and are restated below. They were developed in a manner and worded in way that was culturally sensitive to the target population of interest (Inman, Howard, & Hill, 2012) as it is important that the sample fits the research questions and vice versa (C. E. Hill & Williams, 2012). Generally, hypotheses are not included in qualitative research as the researcher did not have any preconceived notions of the directionality of the results (C. E. Hill, Thompson, & Williams, 1997).

1. How often do African American pastors have congregation members disclose anxiety, depression, bereavement, unemployment, and relationship issues?
2. How do African American pastors respond (behaviorally) to congregation members who are seeking their counsel on issues related to anxiety, depression, unemployment, familial concerns and/or bereavement?
3. What factors influence African American pastors' decision on whether to refer members of their church to seek mental health services outside of the church?
4. How do African American pastors perceive mental health service delivery in their community?
5. Do African American pastors encourage religious coping behaviors that neglect or recognize biological, psychological, or social factors? Further, do they distinguish between adaptive and maladaptive religious coping?
6. How do African American pastors apportion anxiety and depression across biological, social, psychological, and spiritual spheres of influence?

Participants

The population of interest for this study was African American pastors of predominately African American congregations, referred to collectively as the Black Church, because of their experience with the subject matter under investigation (Heppner & Heppner, 2004). The sample included 8 participants, a sufficient number of participants according to Consensual Qualitative Research (CQR) experts (C. E. Hill et al., 1997). Depending on the degree of homogeneity within the sample, C. E. Hill and Williams (2012) suggested that a researcher could expand the sample size to 15, allowing

for subsamples within the larger sample. For the current study, it was anticipated that participants' narratives would be in-depth and too many participants may have provided overwhelming amounts of data that would have been more difficult to analyze (C. E. Hill, 2012). Further, adding additional participants was unlikely to add meaningful findings (Heppner & Heppner, 2004; C. E. Hill et al., 1997). It was anticipated that 8-10 participants would allow the research team to adequately assess for both consistency and discrepancy among the participants. To recruit potential participants, C. E. Hill et al. (1997) suggested using a random sample as an ideal but also acknowledged the difficulty of random sampling within this research paradigm. Accordingly, participants for this study were recruited via non-random purposive sampling (C. E. Hill et al., 1997).

Recruitment Procedures

Recruiting participants in qualitative research can be difficult because of the amount of time and energy participants will be asked to dedicate to the research study, the sensitivity of the subject matter, and lack of trust in researchers. Additionally, researchers have found that participants are reluctant to agree to be a part of qualitative studies because they will be audiotaped. On the other hand, participants are more likely to volunteer if they believe that the topic is interesting and they have a desire to be helpful. Because of these variables, the recruitment process and sampling procedure is very important in qualitative research (C. E. Hill & Williams, 2012). Purposive sampling, an important quality of CQR, was used to recruit participants because it was necessary that participants meet the criteria of self-identifying as African American and being a pastor of a predominately African American church (Patton, 1990). Variability in the sample is

not imperative in qualitative research because generalizability is ultimately not the desired outcome as it is in quantitative research (C. E. Hill et al., 1997). Instead, qualitative researchers desire transferability in which they can apply the findings to members of the studied population outside of the small sample. In order to achieve this transferability, the sample must be clearly defined and appropriately recruited (C. E. Hill & Williams, 2012).

Initial participants in the study were identified through the researcher's contacts in two communities, one urban and one rural, in North Carolina. This allowed for some consideration of urban versus rural issues that may emerge. The researcher also conducted a online search for pastors in two regions of North Carolina and contacted potential participants generated from this search via email or telephone. Participants were also given the option to notify other potential participants who may have been interested in participating. This allowed the researcher to recruit via the snowball method. (Patton, 1990). This method was considered advantageous because researchers have shown that participants are more likely to agree to be a part of a research study when a colleague or friend requests or encourages their participation (C. E. Hill & Williams, 2012). Initial participants were asked to contact additional potential participants to ask them to consider participating. C. E. Hill and Williams (2012) suggested tailoring the recruitment method to the specific population. In this instance, because of the network of Black pastors, it was considered likely that referrals by colleagues will generate additional interest. In this study, no participants were recruited via the snowball method.

To recruit participants, the researcher sent out an initial personalized email to each potential participant that included information about the research study (including approximate time commitments, rationale for the study, and measures that would be taken to protect one's confidentiality [see appendix B]). In cases where the potential participant did not use email, they were contacted by telephone. In some cases, this email (or initial phone call) was followed up by a telephone call to help generate more interest and to help establish additional rapport between potential participants and the researcher; however, no more than three invitations were sent (either by email or phone) to potential participants to avoid unfairly burdening, harassing, or pressuring anyone (C. E. Hill & Williams, 2012). Those who expressed interest in participating were then provided with additional information and documents required for participation. An informed consent document, preapproved by the Institutional Review Board (IRB) (Appendix J) at The University of North Carolina at Greensboro (UNCG), was also attached to an email that provided the participants with more detailed information about the study and the researcher's contact information. If the potential participant did not use email, this information was forwarded using traditional mail. Because of some of the churches' structural organizations and procedures, some of this communication was done between the researcher and administrative assistants at the request of the pastors.

In the informed consent, participants were informed that their interviews would be audiotaped but that the research team valued their privacy and would take proper precautions to protect their anonymity. To protect anonymity, information about the participants was stored in a password-protected computer, only accessible by the student

researcher. Anonymity is particularly important in qualitative research because of the in-depth information retrieved from the interviews and the potential for participants to be identified by their responses (e.g., a pastor identifying the name of her or his church in the interview). Potential participants were also reminded that they have the right to withdraw from the study at any time without fear of penalty or repercussion. Again, the researcher provided interested parties with her contact information and encouraged them to contact her if they needed clarification or had additional questions throughout the process (C. E. Hill & Williams, 2012).

Description of the Sample

The participant sample was comprised of eight participants, seven males and one female. Participants represented various denominations. One participant identified as Full Gospel, three participants identified as Baptist, three participants identified as Non-Denominational, and one participant identified as Holiness.

Congregation sizes ranged in membership size from 72 members to 4,200 members with a mean of 857 members and a median of 325 (*SD* = 1399.50). Participants ranged in age from 28 to 69 years of age, with a mean age of 41 years old (*SD* = 14.2), at the time of the interview. Participants represented both urban and rural areas, with four participants pastoring churches in more urban geographic regions and three participants pastoring in more rural geographic regions. One participant (Participant 5) pastored two churches, one located in a more urban area and the other in a more rural area. Participants' years of pastoral experience ranged from 2 years to 37 years, with a mean of 16 years of experience (*SD* = 11.88). All of the participants indicated having other staff

positions, some paid and others un-paid. Participant 4 had the largest staff, with 6 executive staff members and 24 non-executive staff members. Because of church protocol, Participant 4's daughter was also present during the interview. She signed an informed consent and contributed to the interview by providing responses to the questions as well as clarifying questions for Participant 4. Her demographic information is not included in the descriptive statistics as she does not meet inclusion criteria as a participant, however, some of her responses will be included in Chapter IV in the summary of findings. She serves as a Youth Pastor in the church and is on his executive staff and has constant contact with members, providing primary support for the youth in the church.

Because of the emergent nature of qualitative research, careful attention was paid to protecting the participants throughout the process as it is impossible to predict what emotions may arise for participants during the interviews (Hadjistavropoulos & Smythe, 2000; Orb, Eisenhauer, & Wynaden, 2001). Participants were notified in the informed consent document of the potential emotional risks that were associated with the study as this topic could potentially evoke negative emotions or stir up previously suppressed or unknown feelings. The researcher was prepared to provide additional resources for any participants who showed any signs of distress during the interviews or who exhibited signs of negative mood during post-interview debriefing process (Hadjistavropoulos & Smythe, 2000). Those resources included referrals for counseling services but also alternative helping professionals (i.e. other pastors who could provide support) for pastors who express opposition or discomfort with secular counseling. Only one

participant exhibited slight signs of emotional reactions during the interview and the researcher provided resources for secular counseling, as he did not pose any opposition to secular counseling, and in fact requested these as resources for his congregation and his family.

Interview Questions

Rather than the traditional researcher developed questionnaires common in many quantitative studies, qualitative researchers utilize in-depth processes such as interviews, case studies, and focus groups to collect data. These types of inquiry can help to empower participants whose voices are otherwise not as frequent or familiar in counseling research (Banyard & Miller, 1998). For this study, the lead researcher used a semi-structured interview, developed in collaboration with the dissertation committee, to collect data from the participants (C. E. Hill, 2012). Because the research questions are descriptive and the study exploratory in nature, the interview was considered appropriate to gather data and allow the researcher to hear the participants' own words, which complement other quantitative and qualitative findings (Drew, 1980; Heppner, Wampold, & Kivlighan, 2008). The interview included open-ended questions designed to evoke a narrative that could not have been captured through numbers generated from Likert scales (C. E. Hill, 2012). The number of questions was limited to nine so that the interview might be limited to approximately 60 minutes, using guidelines previously established in the literature (Burkard, Knox, & Hill, 2012). Actual interview times ranged from 35 minutes to 1 hour and 15 minutes, with a mean time of 53 minutes (SD = 16.24).

Along with the dissertation chair, the student researcher consulted with other members of her dissertation committee who have previous experience developing interview questions for CQR studies (C. E. Hill et al., 2007). Questions were based on existing literature as well as personal experiences, which is appropriate for qualitative research (Burkard et al., 2012). The student researcher also consulted with her pastor to develop questions in order to gain feedback from a pastor's perspective who has an in-depth knowledge of the subject matter. The questions were modified based on feedback from the student researcher's pastor, members of the committee, research team, and auditor.

To maintain consistency in the interviews, the principal investigator conducted all interviews based on guidelines for CQR interviews documented by various CQR experts (Burkard et al., 2012; Heppner & Heppner, 2004; C. E. Hill et al., 1997). The researcher was also intentional about separating the role of researcher from clinician as it can be detrimental to the rigor of the research protocol to mix the two (Orb et al., 2001). To help maintain this distinction, the interviewer was careful to approach this as a research interview rather than a clinical interview that would include more reflections and interpretations of interviewees' statements.

There are a number of choice points in the CQR methodology. Although CQR protocol allows for two different interviewers (Hays & Wood, 2011), the researcher only used one interviewer in this research study. Additionally, C. E. Hill et al. (1997) suggested that the interviewer consider whether to provide the participant with questions in advance of the interview. For this study, participants did not review the interview

questions ahead of time in an effort to minimize the possibility of participants developing socially desirable responses. Rather, the participants were notified of general themes to expect during the interview. One participant requested to review the interview questions before he began the interview.

Through the interview, the researcher aimed to establish rapport and gather quality data. According to scholars, quality data includes consistent as well as divergent thoughts among the participants (Burkard et al., 2012). In order to make the participants feel as comfortable as possible, the researcher spent time at the outset of the interview establishing rapport (Heppner et al., 2008). Accordingly, initial questions in the interview sequence were selected because they were considered more superficial to allow the participant to ease into the interview. This was important to maximize the likelihood of candid responses in the later questions that were potentially more emotionally charged. After the initial rapport building questions, the next set of questions was designed to focus on the main topics of the study. Additionally, these questions were constructed to collect specific examples of exchanges that have occurred between pastors and their congregation members, which could greatly inform the existing body of literature and complement the findings of previous research. That is, rather than focus responses on hypothetical situations, pastors were asked to relate specific experiences they had with members of their congregation. The questions were developed to allow for open-ended responses from the participants and because the interview was semi-structured, the interviewer was able to ask the participants follow-up questions (C. E. Hill et al., 1997) that could elicit further elaboration and provide more detailed explanations (Burkard et

al., 2012). The interview questions were a mixture of background, behavioral, opinion, and knowledge questions (Heppner et al., 2008).

Prior to the interview, participants were asked to complete a demographic questionnaire that included questions about age, gender, relationship status, denomination affiliation, number of church members, geographic region, number of years being a pastor, education level, and degree (see Appendix E) as some of these variables have been found to influence clergy behavior and attitude regarding mental health (Payne, 2008; 2009). The demographic questionnaire also asked pastors to provide information about additional staff members, even allowing them the option of submitting an organizational chart. The demographic questionnaire was expected to take approximately ten minutes to complete. All participants completed the demographic questionnaire in less than ten minutes. The interview questions are listed below:

1. I want to begin by learning a little bit more about you and your ministry. Tell me about your background pastoring in the Black Church.
    a. What are some of the highlights about your journey/call into ministry?
    b. I know that there are many spiritual rewards to being a pastor like seeing people receive Christ and I'm wondering what are 2-3 other parts about being a pastor that you find rewarding?
    c. Tell me about some of the training you have received to prepare you for your pastoral role.
2. Now that I feel I have gotten to know you as a pastor a little more, I would like to ask you a little bit about the church you pastor. Churches are different

and have different ways of balancing the salvation message and social justice message. For example some churches are primarily one or the other while others may be a combination. I'm wondering how you would describe how you balance the two?

   a. If a combination of the two, what percentage would you assign to each?

3. How often do you see individual congregation members facing issues such as anxiety, depression, relationship issues, bereavement, and unemployment?

   a. What other mental health issues do you see?

4. I know that you often see people during some of the most difficult times in their life. How do you respond to a member who seeks your guidance during the following traumatic live events and stressors? With each of these, please describe your process in determining what services a congregation member may need. Please provide a specific example of each.

   a. Anxiety/Depression

   b. Bereavement

   c. Parenting Issues

   d. Relationship Difficulty/Divorce

   e. Unemployment/Financial Concerns

5. I'm wondering as a pastor what is the most challenging part for you in attending to mental health concerns of your congregation members?

6. I want to ask you about how you think about anxiety and depression. There is a model that says issues like depression and anxiety are a combination of

biological, psychological, social, and spiritual factors. What percentage of anxiety and depression do you attribute to biology, psychology, social, and spiritual factors ?

   a. Let's look at each of these factors separately. Do you think it is possible to over (or under) use any particular factor as a coping method? For example, it is possible to overly rely on (or neglect) on biological forms of coping, such as medication?

7. Could you provide an example of a time when a congregation member who had been struggling with an issue used religion as a support that helped them through this time? Can you give me an example of a time when you saw someone use their religion in a way that ultimately did not help them?
8. What are some of your positive and negative experiences with mental health care providers in your community? In this case, mental health care providers include professional counselors, psychologists, psychiatrists, and social workers. Have these experiences affected the way you provide services to your congregation members. In other words, would you refer a member to a mental health provider? Why or Why not?
9. This last question is a bit more personal but I want to remind you about anonymity as your name will not be attached to your interview questions. Based on statistics and from conversations I have had with pastors, it appears that pastors and their families are at an increased risk for experiencing feelings of anxiety and/or depression. Have you or someone close to you ever

struggled with these feelings of anxiety and/or depression. This does not mean that you had to receive a formal diagnosis. Please be as specific as possible, but feel free to share only as much as you feel comfortable.

Consensual Qualitative Research

Qualitative approaches to research are increasing in popularity and credibility (Banyard & Miller, 1998), particularly within the social sciences, as a means of collecting and analyzing data (Hadjistavropoulos & Smythe, 2000). An increasing number of researchers have recognized that choosing qualitative designs does not equate to compromising research integrity or rigor (Freeman, DeMarrais, Presissle, Roulston, & St. Pierre, 2007), and that the two different methodologies do not have to juxtapose one another but rather can complement each other well (Banyard & Miller, 1998). Orb et al. (2001) stated, "qualitative researchers focus their research on exploring, examining, and describing people and their natural environment" (p. 93). The researcher let the research questions drive the specific type of qualitative approach that would best fit this particular study (Creswell, Hanson, Clark Plano, & Morales, 2007) and CQR was thought to be the most appropriate. CQR is a methodology that philosophically falls somewhere between a post positivist and constructivist paradigm (Hays & Wood, 2011; Williams & Morrow, 2006) by allowing the researcher to approach the subject matter with some inherent structure while remaining open to the participants' perspectives and new ideas developed along the way. In accordance with the constructivist perspective, CQR researchers acknowledge and appreciate that there are various perceptions of reality and what is considered as "truth." Although researchers have an appreciation for multiple truths, the

protocol also is established in a way that values consensus of research team members, which coincides with the post positivist philosophy (Stahl, Taylor, & Hill, 2012).

Further, this approach was particularly appropriate for this research topic given the scarcity of the empirical research and the author's intention of contributing empirical knowledge to the existing body of literature (Banyard & Miller, 1998; C. E. Hill, 2012). Using CQR allowed the researcher to understand experiences that could not be simply understood by observations alone (C. E. Hill, 2012) and gave participants an opportunity to tell about specific events and account for their attitudes and beliefs (C. E. Hill, 2012). Moreover, researchers have noted that qualitative approaches are particularly fit for contributing to knowledge related to diversity issues (Banyard & Miller, 1998), which is applicable to this study as the population of interest is from a racial/ethnic minority group.

CQR Data Analysis Process

CQR research follows a fairly well established protocol (C. E. Hill et al., 1997). It is important that qualitative research be carried out according to established protocols and that this protocol be clearly explained to the research consumer (Freeman et al., 2007). Accordingly, the following is a detailed account of the process that was followed in the current study at sufficient depth to support replication of the study (Crook-Lyon, Goates-Jones, & Hill, 2012).

Research Team

According to some researchers, the collaborative quality of qualitative research is one of the appeals and strengths of the methodology (Paulus, Woodside, & Ziegler,

2008), as having multiple people reviewing the data allows for people with different perspectives, various personal experiences, and their own fields of expertise analyzing the same data set (Vivino, Thompson, & Hill, 2012). These various perspectives would be missed if the researcher was the sole analyzer (C. E. Hill, 2012). To increase the transparency of the study, the research team members should be described (Paulus et al., 2008). Members of the research team were recruited by the student researcher, contacted by email or in person and asked to be a part of the research team (Appendix H). Based on the suggestion by Vivino et al. (2012), the researcher was transparent with team members concerning time commitments as she wanted to ensure that people who agreed were motivated and dedicated to the process because it can be very demanding in terms of time and physical, mental, and emotional energy.

For this study, the research team was a "set team" rather than a rotating team, meaning all members read each of the interviews and no members were added during the course of the research project (C. E. Hill et al., 2005). It is important to note that even though this was a "set team," not all members of the research team collected data, but all participated in the analysis process together. With the set team, each member was immersed in the data and had an in-depth knowledge of each of the cases (Vivino et al., 2012). The research team met a total of 4 times, with meetings ranging from one hour to three hours in length.

The lead investigator, also referenced as the student researcher, is a 27-year-old, African American female. She is a doctoral student who is enrolled in a counselor education program in the southeastern part of the United States. She has been an active

member of the Black Church her entire life and previously was a part of a CQR research team on a dissertation about African American religion. Another member of the team was a Caucasian male Professor from the student researcher's doctoral program. He is an expert in the field of religion and spirituality in counseling as he has published substantively on the subject. Additionally, he is an ordained Deacon in a predominately Caucasian Protestant church. He also is well versed on the procedures of CQR, having chaired previous dissertations using this methodology as well as conducting studies of his own using this protocol. The third member of the research team was an African American female Associate Professor at the same university as the other two members of the team. Like the other two members of the team, she also grew up in the Baptist church; however, she now attends a primarily White Catholic church with her husband. She described herself as more spiritual than religious. Prior to this study, she had not had any experience with CQR research protocol.

The research team had an initial meeting to discuss possible power differentials and other foreseeable impacts on the group dynamic. This was an important conversation because group dynamics can impact the analysis process and subsequently the quality of the research. It also was important to discuss goals of the team as Vivino et al. (2012) suggested that some research team members may have alternative motivations for participation, which could include hopes for publication or recruiting members for their own research teams. The research team discussed the potential power differentials in the group, with students and faculty members working together. The researcher recommended strategies such as allowing different members of the team to speak first at

meetings as a means to minimize the impact of power differentials (C. E. Hill et al., 2005). The faculty members of the research team encouraged the student researcher to lead group discussions. The student researcher also encouraged all members to participate equally so that trust could be built amongst the members (Vivino et al., 2012). The researcher also addressed the presence of dual relationships and how that could influence the process. For example, one member of the research team had been the student researcher's professor in classes. The research team also made a commitment to share the work load, each stating that they would work to agreed time deadlines. Additionally, the researcher reviewed interpersonal skills such as active listening to help create an environment for effective communication (C. E. Hill, 2012).

Although the auditor is not considered a part of the core research team, she is considered a crucial part of the CQR process and was vital to this particular study. The auditor has a Ph.D. in Counseling and Counselor Education. She is an African American female and has extensive anecdotal and scholarly knowledge about the Black Church. Additionally, the auditor has conducted previous research using the CQR methodology. The role of the auditor was to provide accountability as well as a fresh perspective to the research team that enhanced the credibility and trustworthiness of the study. The auditor played an integral role throughout the entire research process. One of her responsibilities was to review the interview questions and offer feedback on them as if she was a participant. Schlosser, Dewey, and Hill (2012) suggested that the auditor have certain characteristics in order to be successful which include being confident, independent, thorough, timely, flexible, and attentive to details. Although it is possible to use more

than one external auditor, for this study only one auditor was used as she was thought to be dependable, insightful, and knowledgeable about the study content.

Bracketing

Because qualitative researchers acknowledge that research, whether qualitative or quantitative, is not void of biases (Banyard & Miller, 1998) and neither researchers nor participants are considered neutral in the process (Freeman et al., 2007), it was important for each member of the research team to bracket their experiences pertaining to the Black Church, pastors, and counseling (Heppner et al., 2008; C. E. Hill et al., 1997). Bracketing is a process designed to "mitigate the potentially deleterious effects of preconceptions that may taint the research process" (Tufford & Newman, 2010, p. 80). According to Tufford and Newman (2010), many of these preconceptions often are previously unacknowledged and can highlight emotionally charged and challenging subject matter. Not only does bracketing protect the data but it also protects the researchers by allowing them an opportunity to vent about the topic at hand. Researchers often gain awareness and insight of the topic through bracketing which, in turn, encourages them to participate in a more in-depth investigation of the subject matter. Bracketing can be done in a variety of ways and there is often disagreement concerning both the appropriateness and the necessity of the activity.

Each member was asked to type their biases and expectations and then submit this information to the lead researcher, who then compiled each member's thoughts into a single document that was distributed to the rest of the team during the initial meeting (Sim, Huang, & Hill, 2012). A summary of research team characteristics, biases, and

expectations is included in Appendix J. Biases are defined as personal issues of the team members that can impede their ability to objectively analyze the data while expectations are beliefs that they may have formed about the outcome of the data that could be based on their previous experiences with the population, the research protocol, and the existing literature. The members were encouraged to be honest and participate in some self-reflection and record any biases or expectations that they may have prior to any data collection or analysis. Opinions and preconceived notions about ethnic and racial multicultural issues were also noted in the team member's bracketing activities (Heppner et al., 2008; C. E. Hill et al., 1997).

Bracketing does not stop prior to data collection and analysis but rather continues throughout the research protocol. For example, during the actual data collection process, the interviewer continued to record her biases and expectations about the different interviews, discussing these with fellow research team members during the meetings. Team members were encouraged to share their experiences with fellow team members in an effort to maintain an honest environment and to help minimize feelings of isolation. The expectations and biases were discussed in a way that highlighted themes across the group rather than specific individuals. During these types of discussions, each team member was encouraged to express their opinions (Sim et al., 2012).

Rigor

Instead of terms such as reliability and validity that are typically associated with quantitative research, qualitative researchers use terms such as credibility, trustworthiness, verisimilitude, transferability, relevance, plausibility and confirmability

to describe the rigor and integrity of their studies (Freeman et al., 2007). Trustworthiness has been used to describe the "validity" of qualitative studies (Williams & Hill, 2012). A significant part of trustworthiness in qualitative research is that the study would be one that could improve the wellbeing of people (Williams & Morrow, 2009). In this study, the ability to learn more about how African American pastors provide services for their parishioners could inform mental health practitioners about methods they could use to collaborate with pastors. After the interviews were transcribed, the researcher sent each participant a copy and they were encouraged to notify the researcher if it was not an accurate reflection of their words (Freeman et al., 2007). None of the participants contacted the researcher and said their transcript was inaccurate.

Rather than aiming for generalizability, qualitative researchers seek transferability in which readers are empowered to determine whether they can transfer the findings of this sample to other members of the population. For this study, the researcher has provided detailed information about the sample of African American pastors in this chapter and in Chapter IV. Additionally, responses were categorized as *general* (applying to all cases), *typical* (applying to at least half of the cases) and *variant* (applying to at least two, but less than half, of the cases). Accordingly, transferability is influenced by the extent to which responses were general. That is, if the study produced only variant responses, then the trustworthiness of the study may have been compromised (Williams & Hill, 2012). For this study, seven categories emerged as *general,* ten categories emerged as *typical*, and eight categories emerged as *variant.*

One of the distinguishing characteristics between qualitative and quantitative research is the way the results are written in the final narrative with the participants' words being much like the numbers presented in quantitative results section (Sandelowski & Barros, 2003). In Chapter IV, the researcher has included a "thick description" of the data, defined as "a detailed examination of specific behaviors and the settings in which they occur" (Baynard & Miller, 1998, p. 494), as well as some direct quotes of the participants in an effort to maintain the integrity of the data and enhance the trustworthiness of the study (Heppner et al., 2008; Williams & Morrow, 2009). Moreover, the thick description serves as a way for the researcher to convey specific details and the voices and perspectives of the participants (Baynard & Miller, 1998) and enhance the verisimilitude (Ponteretto, 2006). The participants were notified of this during the recruitment process.

Ethical Considerations

It was important to the researcher that the team adhere to ethical standards of research, especially considering African Americans are considered vulnerable populations and have been the victims of unethical research studies in the past (Orb et al., 2001). In adhering to those ethical standards, the research team worked to ensure that participants were not unnecessarily burdened or unfairly pressured to participate (C. E. Hill & Williams, 2012). This is especially important in light of the history of oppression faced by African Americans. Also, it was important to fully disclose the logistics involved in the study so that interested participants could make an informed decision about participating (Inman et al., 2012). As suggested by Inman et al. (2012) the

researcher was intentional about building emotional relationships with the participants to increase rapport and trust. For as much as research must adhere to standards in the protocol, it was important to be sensitive to participants' culture as they are an integral part of the research process (Inman et al., 2012).

Coding

After the interviews were transcribed verbatim, the research team began the data analysis process. The lead researcher rechecked the final transcripts, comparing the typed words to the audio-recorded interviews to ensure their accuracy (Heppner & Heppner, 2004; Y. S. Lincoln & Guba, 1985). Once the transcripts were accurate and ready for analysis, the research team began coding the data (B. J. Thompson, Vivino, & Hill, 2012) and analyzing individual cases (C. E. Hill, 2012) to develop domains.

Domains. Domains are defined as a "list of discrete topics" (B. J. Thompson et al., 2012, p. 103) and researchers have the option of creating an initial list of domains from the existing related literature and interview questions prior to reading the transcripts (C. E. Hill et al., 1997; B. J. Thompson et al., 2012). According to the CQR protocol, researchers also have the option of letting the domains emerge inductively as they analyze the transcripts. By using the inductive approach in this study, the research team remained immersed in the data as each member individually reviewed the transcripts, created a proposed domain list, and presented his or her list to other team members during a meeting. Team members compared the domain lists, over a span of three research meetings, and the student researcher created a master list of domains for the entire group based on consensus. During these meetings, each team member articulated

rationales behind each proposed domain that included the associated raw data. Team members were encouraged to disagree and question one other to enhance the quality of the findings. The team members were also given the option to review the audiotapes again to add more context to the transcribed versions. As the domains were created, the team remained open to change as members constantly checked the created domain against transcripts to ensure that the domains are still appropriate to the raw data. Thus, some original domains changed throughout the analysis process (B. J. Thompson et al., 2012). The finalized list of domains included six domains.

The domains are considered to be relatively general compared to the more detailed categories that were ultimately created (i.e., core ideas) and were clustered in a way that grouped related topic areas. Moreover, if domains became too numerous or too specific, it could have complicated the data analysis process. Once the research team reached consensus, the list of domains was given to the auditor for review. The auditor did not recommend any changes to the domain list; however she suggested that in the "thick description" of the data the researcher provide specific examples of pastoral responses to members suffering with unemployment, bereavement, anxiety, depression, and family concerns.

The team grouped phrases of the interview responses into the different domain areas, intentionally including enough information in the phrase to understand the context around the answer. In some instances, groups of data were categorized in more than one domain. The researcher and fellow team members continued to check if they were double-coding too often, as this could be an indication that some of the domains were too

similar and could be combined to make the data more parsimonious. Although there was some double coding it did not seem to be too much. Through this process, there was some data that remained uncoded. Any data that was uncoded and considered to be "junk data" was unanimously agreed upon by the entire research team. The team agreed to not include these pieces of data in the final narrative. There was also some data that did not fit into a particular domain; however, rather than being grouped into the "junk data" it was categorized in the "other" domain. Any data that was placed in the "other" domain was reexamined to see if a new domain was warranted. The lead researcher assumed primary responsibility for creating the consensus version of the data organizing the findings in a table format (B. J. Thompson et al., 2012). Following these steps, the team proceeded to use those constructed domains and the associated raw data from the transcripts to continue to the next part of the CQR process, creating core ideas (C. E. Hill et al., 1997).

Core ideas. Core ideas paraphrase the participant's words in a more concise format and are designed to capture the essence of the participants' responses. By using more concise words and universal language, the team members were able to cross-analyze the data (B. J. Thompson et al., 2012). Although Freeman et al. (2007) argued that true raw data does not exist, as no words are exempt from human interpretation, the term *raw data* will be used to refer to the actual words of the participants. Core ideas were derived less from the researchers' interpretations and more from the participant's actual words (C. E. Hill et al., 1997). In fact, researchers worked as a team to ensure that other members were not adding interpretations to the raw data that extended beyond the

words themselves. The research team began by analyzing a few cases together before transitioning into more independent work. After constructing core ideas in a few cases together, the research team created the core ideas independently and then reconvened for the consensus process in which they worked to unanimously agree on their findings. The core ideas were created to capture the essence of the participants' responses without including too much detail. The research team created a separate core idea for any data that was coded in multiple domains. After the core ideas were created, the lead researcher completed the finalized consensus version. The auditor reviewed the consensus version and offered suggestions to the research team (B. J. Thompson et al., 2012). The auditor suggested a possible core idea to reflect participants mentioning contextual considerations (i.e. economy) in their experiences with mental health in their congregation. The research team consulted and decided to honor this suggestion in the Chapter IV write-up by including participant quotes to reflect these nuances in the appropriate categories.

Cross-analysis. After each individualized case was analyzed, the team proceeded to analyze the cases against each other in what CQR developers refer to as the cross-analysis. Just as the research team made adjustments for individual case analysis based on feedback from the auditor, they also reviewed auditor feedback and made appropriate changes to the cross-analysis (C. E. Hill, 2012). Specifically, the auditor suggested that the research team be sure to reflect participant's thoughts about duration and severity of mental illness in the referral process. These nuances are reflected in the "thick description" of Chapter IV. During the cross analysis process, each domain was studied

individually and the team will began the cross-analysis with the smallest domain (i.e. domain with the fewest core ideas). In this study, the smallest domain was *Frequency/Type of Mental Health Issues.* By beginning with the smallest domain, the research team was able to practice protocol and increase competence as they moved on to larger domains (Ladany, Thompson, & Hill, 2012).

Categories. The research team grouped the core ideas together and labeled them according to themes. Categories were created based on the core ideas in each domain. The category names were based on the data rather than any interpretations and biases of the research team members. The team members developed category titles individually and came together as a unit to discuss and reach consensus. There is no set number of categories recommended by CQR experts and the number of categories in each domain differed based on the information given by participants. As recommended by CQR experts, the research team began hypothesizing throughout the data analysis process about how all the data would group together. The core ideas from each of the cases were placed in the domain categories. If at any time the research team found the core ideas confusing, they referred back to the raw data to find the context and gain better understanding. This helped them fit the core idea into the most appropriate domain. The research team repeated the categorization process for each domain. Core ideas that did not fit into a particular category were grouped into an "other" section (Ladany et al., 2012).

Labels. The research team then determined the frequency of the categories by labeling them as *general*, *typica*l, or *variant* based on the category's frequency in the

whole sample. For example, if a category included data from each participant, it was considered *general*. If one participant was missing, the category was still labeled *general*. If half of the participants had the same idea, then that category was considered to be *typical* (Ladany et al., 2012). If an idea existed in only two to three of the interviews, however, then it was considered to be *variant* (C. E. Hill et al., 1997; Ladany et al., 2012; Welch, 2010). As suggested by CQR experts (Ladany et al., 2012), the research team monitored the frequency count and ensured that all the categories were not *variant* or *general* (Ladany et al., 2012). At the end of the cross-analysis, the lead researcher compiled all the individual cases into one document that is referenced by Ladany et al. (2012) as "the beast" because of the massive amounts of information included. In this document, all of the domains were listed along with each of the core ideas from all the cases (Ladany et al., 2012). "The beast" was also given to the auditor for her review. The auditor suggested that the researcher be attentive to how demographic variables may have influenced some of the findings. For example, the auditor suggested that the researcher think about education and age of the participants when discussing results in Chapter V.

Pilot Study

The pilot study was an important component of the research process and provided the researcher a means to field test the interview questions and process (C. E. Hill, 2012). Essentially, the pilot study consisted of two parts. In the first part, prior to field testing the interview process, the lead researcher went through two processes to refine the interview questions. First, she met with a clergy member of a Black Church to receive feedback on proposed interview questions. At this meeting, the lead researcher reviewed

the interview questions with the pastor and he provided feedback from a pastoral perspective. These revisions were then distributed to three members of the dissertation committee and the research team auditor, who reviewed the questions and provided additional feedback and recommendations.

The second part of the pilot study involved field testing the interview process with an African American pastor to get additional feedback on the proposed questions and pilot test the interview process. The pilot served as an opportunity for the researcher to get a sense of the duration and flow of the interview and assess the appropriateness of the interview questions.

Phase 1

In the first phase of the pilot study, two processes were implemented to refine the interview questions and process. The lead researcher constructed the initial interview questions. To further refine the questions, the researcher consulted with a pastor with knowledge of interview content and three dissertation committee members, all of whom had backgrounds as researchers using either CQR or some other qualitative methodology. Based on a suggestion of the pastoral consultant, the researcher changed the format of the interview to begin by asking the pastors a question about their journey into ministry in an effort to build rapport and to direct the participants to highlight a couple of items in an effort to circumvent prolonged responses. Otherwise, the pastoral consultant had no additional recommendations.

The four expert reviewers agreed that the language of question #3 could be potentially confusing and complicated for pastors of all education levels to answer. The

researcher modified the language used in the follow up question to #3 to be less academic in nature. Rather than asking the original question, “How would you describe your church”? and including a follow up question that asked,

> According to scholars there are two primary different types of churches “this worldly” and “other worldly.” Typically, “this worldly” churches have a present focus, working to achieve happiness in this present life and “other worldly” tend to be more focused on the afterlife and the promises of reward in heaven. How would you describe your church using this language?

the interviewer will ask the question using more familiar language:

> Now that I feel I have gotten to know you as a pastor a little more, I would like to ask you a little bit about the church you pastor. Churches are different and have different ways of balancing the salvation message and social justice message. For example some churches are primarily one or the other while others may be a combination. I’m wondering how you would describe how you balance the two?

Additionally, the researcher included a follow up question that allowed interviewees to elaborate if they believed it to be a combination of the two (“If a combination of the two, what percentage would you assign to each?”). Upon the recommendation of the pastoral consultant, the lead researcher also expanded question 4 (“I know that you often see people during some of the most difficult times in their life. How do you respond to a member who seeks your guidance during the following traumatic life events and stressors?” With each of these, please describe your process in determining what services a congregation may need) to be more specific and address anxiety, depression, bereavement, parenting issues, relationship difficulties, and unemployment. Further, the lead researcher moved original question #5 (“Have you or someone else close to you ever

struggled with anxiety or depression? Please be specific as possible, sharing as much information as you feel comfortable") to the end of the interview to allow the interviewee time to adjust and become as comfortable as possible before sharing personal information about their own struggles with anxiety and depression. The researcher also added language to normalize their experience by stating that anxiety and depression appeared to be a common issue among pastors and their families. The revised question now reads

> This last question is a bit more personal but I want to remind you about anonymity as your name will not be attached to your interview questions. Based on statistics and from conversations I have had with pastors, it appears that pastors and their families are at an increased risk for experiencing feelings of anxiety and/or depression. Have you or someone close to you ever struggled with these feelings of anxiety and/or depression. This does not mean that you had to receive a formal diagnosis. Please be as specific as possible, but feel free to share only as much as you feel comfortable.

Based upon feedback from the various consultants, the lead researcher also added a question that asks for a specific example of an experience the participants have had with congregation members using religion as an adaptive and maladaptive coping. Some of the consultants also expressed concern about clarity in some of the questions. The initial question 8,

> I want to ask you about anxiety and depression. There is a model that says issues like depression and anxiety are a combination of biological, psychological, social, and spiritual factors. What percentage of anxiety and depression do you attribute to biology, psychology, social, and spiritual factors

was expanded to include examples of coping strategies to increase clarification for interviewees. The revised question includes a follow up that reads,

> Let's look at each of these factors separately. Do you think it is a possible to over (and under) use any particular factor as a coping method? For example, it is possible to overly on (or neglect) biological forms of coping, such as medication.

A list of the original questions, developed by the researcher in consultation with her dissertation director is included in Appendix F. The revised version of the questions, used in the pilot study, is included in Appendix G.

Phase 2

Once the questions had been refined in Phase 1 of the pilot study, phase 2 was implemented, in which the interview questions and process were field tested through an interview with a pastor from a Black church. A description of this process and modifications to the full study based on the interview are provided here.

The participant identified as a male African American pastor in a predominately African American congregation of approximately 300 members from the eastern North Carolina region. Prior to the interview, the author was familiar with the participant as he occasionally visits the lead researcher's church. In addition to being a pastor, the participant also is employed as a full-time chaplain at a hospital in the eastern North Carolina region. The participant was consulted based on the recommendation of the initial pastoral consultant used in the development of the interview questions.

The researcher initiated the pilot study by contacting the participant via telephone and inviting him to be a part of the study. The participant agreed and an interview time was agreed upon as the lead researcher advised the participant that the entire interview process would last approximately 2 hours because she would be asking him to provide feedback about the interview at the end.

Prior to conducting the interview, the participant signed an informed consent agreeing to participate. Additionally, the participant agreed that he would give feedback regarding the interview questions and the flow of the interview. The participant was asked to complete a demographic questionnaire before beginning the qualitative interview portion. The demographic questionnaire took approximately one minute for the participant to complete. In total, the demographic questionnaire, qualitative interview, and feedback afterwards took 1 hour and 51 minutes to complete.

Results

Following the qualitative interview, the participant offered feedback for the researcher. The participant communicated that he felt the research study was much needed in the religious community. The researcher asked the participant how objectively she presented the questions during the interview. The participant commented that some of the questions elicited some responses that were intimate in nature and that it was helpful that the researcher presented in a non-threatening, inviting manner. Additionally, the participant commented on the open-ended nature of the questions allowing space for dialogue. The participant noted that for some pastors who may be less educationally advanced in the area of counseling, they may rely solely on biblical scriptures in their response to avoid personal answers. To redirect pastors, the participant suggested the researcher use language such as “emotional” or “natural” to encourage more in-depth responses, particularly in the final question. Further, he added that when future participants avoid questions about depression or anxiety to instead use more inviting language such as sadness or pain. The participant ended the interview by providing the

lead researcher with names of pastors who may be interested in participating in the full study.

During the interview, the researcher noticed that question 3 (I'm going to transition now and ask some more specific questions about providing support to congregation members. How do you see your role in attending to the mental health needs of members of your congregation? For example, how would you describe your role if a member approached you and stated that they were struggling with anxiety and/or depression?) and the follow up question for question number 4 were similar. In fact during the pilot interview, the participant answered 4a during his response to question 3. The researcher decided to eliminate question 3 and request the participants provide a specific example in their responses to question 4.

When reviewing the demographic questionnaire, included in Appendix D, the lead researcher realized during the interview that she would have liked to have information on relationship status of the participant. This demographic information could be important to have as some of the interview questions address family and relationships. Also, the terminology "church size" on the demographic sheet seemed somewhat ambiguous in meaning so the lead researcher changed it to read "number of congregation members". The revised demographic questionnaire is included in Appendix E.

Modifications

The lead researcher and dissertation chair each listened to the audiotape of the interview and offered suggestions for modifications. The chair expressed some concerns about the length of the interview and encouraged the lead researcher to redirect or gently

interrupt participants if the responses became lengthier and less focused. The lead researcher and dissertation chair noted a need to include possible follow up questions to encourage the participants to elaborate further while still remaining on topic. Although the lead researcher's dissertation chair and pilot participant provided feedback suggesting that the researcher remained objective as an interviewer, the dissertation chair encouraged the lead researcher to be intentional about remaining objective as she proceeded forward and encountered participants whose values and beliefs differed from hers. The researcher also had the pre-constructed follow up questions to assist in accountability in remaining objective. The follow up questions are included in Appendix I. To adequately address research question 1, the lead researcher and dissertation chair decided to add an additional interview question that addressed frequency of these mental health issues (i.e. anxiety, depression, unemployment, bereavement, and relationship concerns). Additionally, they added a follow up question that allowed participants to indicate other mental health concerns they see frequently.

Additionally, based on recommendations during the proposal seminar the researcher added questions to the demographic questionnaire to attain information about the organization of the churches including additional staff positions.

CHAPTER IV

RESULTS

> You will get knocked down from time to time. But you've got to know that the thing on the inside of you is greater than whatever situation that is going.
>
> – Participant 1

Overview

Through this study, the researcher investigated how African American pastors responded to the mental health concerns (i.e. anxiety, depression, bereavement, financial concerns, and familial issues) of their congregation members. The researcher used a semi-structured interview (see Appendix I) to pose questions to participants regarding the subject matter, including their beliefs about causes of mental health issues, their attitudes and beliefs about coping, their behavioral responses to congregation members, their ideas about balancing salvation and social justice, and personal experiences with anxiety and depression. In the following chapter, demographic information about the participant sample is provided as well as results to each of the research questions from the qualitative analysis.

Description of the Sample

A total of eight participants were interviewed for this study. Interviews varied in length from approximately 1 hour and 15 minutes (Participant 1 and Participant 8) to 35 minutes (Participant 2), with a mean length of 53 minutes (SD = 16.24). All participants were senior pastors of predominately African American congregations and over 18 years

old as delineated in the inclusion criteria discussed in Chapter III. Additionally, all participants (n = 8) identified as African American. Participants ranged in age from 28 to 69 years of age, with a mean age of 41 years old (SD = 14.2) at the time of the interview. One of the participants did not specify an age and instead provided a range from 40-50 years old and thus the researcher selected the midpoint of 45 for this participant to be included in the descriptive calculations. Educational statuses of the participants varied. One participant (Participant 6) held a high school diploma, two participants (Participants1 and 8) had attended some college, three participants had bachelor's degrees (Participants 2, 3, and 4), one participant had a master's degree (Participant 7), and one participant had a doctorate degree (Participant 5). Participant 2 held a bachelor's degree in special education. Participant 3 held a bachelor's degree in psychology and is currently pursuing her master's in counseling. Participant 4 held a bachelor's degree in divinity from a bible college. Participant 7 had a master's of divinity from a seminary institution and Participant 5 held a doctorate of theology from a seminary institution. All of the participants, except Participant 5, were full time pastors. Participant 5 is a senior administrator at a university in the southeast region of the United States and works part-time as a church pastor. The structure of Participant 8's church was unique from other participant's churches in the study, in that he operated in the role of senior pastor of his local congregation while still remaining a part of a district of churches in which the overseeing Bishop is very active in the functions of the church. Three pastors identified as Non-denominational (Participants 1,3, and 6), three identified as Baptist (Participants 2, 5, and 7), one identified as Full-Gospel (Participant 4) and one participant identified as

Holiness (Participant 8). Non-denominational churches are considered to be independent of a particular denominational affiliation. Holiness is a denomination that is considered to be a form of Pentocostalism in which they believe in "the requirements of conversion and of holiness or sanctification as perquisite for sanctification" (Lincoln & Mamiya, 1990, p. 77) . Accordingly, the Full Gospel denomination is also a form of the Pentocostal denomination in which people are encouraged to freely express the spiritual gifts given by the Holy Spirit (i.e. speaking in tongues; Full Gospel Baptist Church Fellowship, 2012). The Baptist denomination has origins in the southern geographic region of the United States and is known for "enthusiastic and demonstrative worship" (Lincoln & Mamiya, 1990, p. 20).

Seven of the eight participants identified as male, while one of the participants identified as female (Participant 3). One of the participants identified as being single (Participant 2), while seven of the participants identified as being married. Four of the participants (Participants 5, 6, 7, and 8) pastored churches in more rural areas while four of the pastors (Participants 1, 2, 3, 4, and 5) led churches in more urban areas. Participant 5 pastored two churches, one in an urban area and one in a rural area. Participants have a range of 2 -37 years of experience, with a mean of 16 years of pastoral experience (*SD* = 11.88). The participants pastored churches that ranged in membership sizes from 72 members (Participant 1) to 4,200 members (Participant 4), with a mean of 857 members and a median of 325 members (*SD* = 1399.50). Because of the skewness in the distribution the churches are grouped into categories of small, midsized, and large churches. For this study small church was considered 72-250 (*M* = 139). Midsize was

considered 251-500 (*M* = 450) and larger churches were considered those of over 500 members (*M* = 2700). All of the participants indicated having other staff members within the church, some paid and others un-paid. Consistent with the atypically large size of his church, participant 4 had the largest staff, with 6 executive staff members and 24 non-executive staff members. Because of church protocol, Participant 4's daughter was also present during the interview. She signed an informed consent and contributed to the interview by providing responses to the questions as well as clarifying questions for Participant 4. Her demographic information is not included, as she does not meet inclusion criteria as a participant; however, some of her responses are included in the summary of findings. She serves as a Youth Pastor in the church and is on his executive staff and has constant contact with members, providing primary support for the youth in the church.

Table 1. Descriptive Statistics

	N	Range	Min	Max	M	SD
YearsExperience	8	35.00	2.00	37.00	16.00	11.88
Age	8	41.00	28.00	69.00	51.88	14.21
No. of members	8	4128.00	72.00	4200.00	857.13	1399.49
Valid N (listwise)	8					

Overall, participants seemed to value training as a part of their journey into the ministry but acknowledged that training can come in various forms. Although specific requirements could differ depending on the local churches and denomination affiliations, often pastors are not required to receive formal education, rather they receive a "calling"

to become a pastor (Lincoln & Mamiya, 1990). Pastors spoke about formal and informal methods of preparation for ministry with Participant 1 stating that, "there must be some training." Participant 1, 2, and 7 indicated that much of their training came from hands-on experience. Participant 2 even indicated, "There is no training that can prepare you to be a senior pastor." There also seemed to be a number of pastors who received mentoring from their pastors and other leaders in the church. Participant 1, 3, 4, 5, 6, 7, and 8 spoke about the guidance and training they received from within the church as valuable in their pastoral career. Participant 4 stated, "I'm a preacher's kid. Been around the church all my life. My daddy was the pastor of the church." Participant 1 spoke about his childhood in the church saying, "I always liked church." Conversely, Participant 2 spoke about a period in his life when he "had some issues with the Black Church and for a minute I ended up just sort of sitting out church, getting deprogrammed and just really spending time trying to get to know God outside of the church." Some pastors, namely 4, 5, and 7 spoke about their academic training to become pastors, which included focusing on theology, religion, and divinity in their studies. Participant 3 stated that she was currently in graduate school pursuing her master's in counseling.

Participants also were asked about how they balanced the salvation message and social justice efforts in their respective churches in order to gain insight on the theological stance of the churches. All of the participants except Participant 7 spoke about achieving a balance in the church, emphasizing salvation while responding to injustices in the community. Participant 1 noted, "The salvation part is the foundation, is the part that distinguishes us from other organizations." When asked to assign a

percentage to how much time they spent on salvation versus social justice, the majority of the participants indicated that they devoted 60% of their time to "gospel proclamation", as stated by Participant 5, and 40% of their time to social justice issues. Often, participants added that this percentage could change depending on environmental influences. For example, Participant 8 described the mass shootings (i.e., Sandy Hook Elementary and Aurora, Colorado) as shaping his most recent sermons to his congregation. Participants 3 and 7 disclosed that they had gone on international mission trips and noted this as one of the highlights of their ministry. Participant 3 referenced her international ministry as one of the defining characteristics of her ministry.

Summary of Findings

The author used a qualitative methodology, Consensual Qualitative Research (CQR), to analyze the participants' responses from the semi-structured interviews. As mentioned in Chapter III, CQR is a methodology that falls between a constructivist and post-positivist perspective, in that it allows for the participants' responses to represent multiple truths while integrating some inherent structure through the data analysis process. Thus, these findings are a reflection of the participant's voices and the consensus of the research team. One of the core elements of the CQR data analysis process is the research team. A research team, consisting of 3 primary members and one auditor, analyzed the data to reach consensus regarding findings. The team categorized responses into domains, core ideas, categories, and assigned labels with frequency counts. These findings are illustrated in Table 2. For this study, based on the number of participants and guidelines defined in C. E. Hill et al. (1997) and C. E. Hill et al. (2005), the *general* label

was assigned when the category appeared in 7-8 of the cases, the label *typical* was assigned to categories that appeared in 4-6 cases, and finally *variant* was assigned to categories that appeared in 1-3 cases.

Table 2. Domains, Core Ideas, Categories, and Labels

Research Questions	Domain	Core Idea	Category	Respondent	Label
How often do African American pastors have congregation members who disclose mental health issues such as anxiety, depression, bereavement, unemployment, and familial issues?	Frequency/type of mental health issues	"just about every day of the week" (2)	Frequency	1, 2, 3, 4, 5, 6, 7, 8	General
		"what I see mostly at my situation is a lot of depression" (7)	Type	2, 3, 5, 6, 7	Typical
How do African American pastors respond (behaviorally) to congregation members who are seeking their counsel on issues related to anxiety, depression, bereavement, unemployment, and familial issues?	On being a pastor	"You'd be shocked at the kind of things people ask" (1)	Complex roles	1, 2, 3	Variant
		"things that are already in existence we use it"	Resources	1, 2, 3, 4, 5, 6, 7, 8	General
		"pastor as a powerful influencer" (5)	Black Church	2, 3, 5	Variant

Table 2 (cont.)

Research Questions	Domain	Core Idea	Category	Respondent	Label
		"seeing people's lives transformed and become whole" (3)	Development	3, 4, 5, 6, 7,8	Typical
What factors influence African American pastor's decision on whether to refer members to seek help outside of the church?	African American experience	"there shouldn't be no shame or guilt when you are dealing with some mental faculties" (7)	Stigma	4, 5, 7, 8	Typical
		"black children react different" (4)	Contrast	4, 5, 6	Variant
		"bringing history into the Christianity" (6)	History	2, 6, 7, 8	Typical
How do African American Pastors perceive mental health delivery systems in their community?	Perspectives on mental health services	"the ones I know I think they care about people" (6)	Positive	1, 2, 3, 4, 5, 6, 7,8	General
		"lack of empathy that workers provide" (8)	Negative	2, 3, 6, 8	Typical
Do African American Pastors encourage religious coping behaviors that neglect or recognize biological, psychological, or social factors? Further, do they distinguish between maladaptive and adaptive religious coping?	Coping with mental health	"the only foolproof plan I know is the plan of God" (1)	Spiritual	1, 3, 4, 5, 6, 7,	Typical

Table 2 (cont.)

Research Questions	Domain	Core Idea	Category	Respondent	Label
		"I believe that good solid counseling is a good thing" (3)	Psychological	3, 5	Variant
		"communicating to people they are not alone" (1)	Social	1, 2, 4, 6, 7, 8	Typical
		"sometimes people's wounds are so deep that it takes more than just a prayer and a sermon" (4)	Complex	1, 2, 3, 4, 5, 6, 7, 8	General
		"it increased their faith and brought them closer to God" (3)	Adaptive coping	1, 2, 3, 4, 5, 6, 8	General
		"we overuse the spiritual when we don't face reality" (7)	Maladaptive Coping	1, 2, 3, 4, 5, 6,7, 8	General
		"you set it aside and it builds" (8)	Avoidance	2, 3, 6, 7, 8	Typical
		"there's got to be some discipline" (1)	Personal Responsibility	1, 3, 6	Variant
		"I refuse to be down" (1)	Personal experiences	1, 2, 3, 4,5, 6, 7, 8,	General
How do African American pastors apportion anxiety and depression against biological, psychological, social, and spiritual spheres of influence?	Causes of mental health	"so biologically right, that doesn't mean I'm not saved" (5)	Biological	5	Variant

Table 2 (cont.)

Research Questions	Domain	Core Idea	Category	Respondent	Label
		"prayers unanswered will make someone depressed" (8)	Spiritual	1, 5, 6, 7, 8	Typical
		"we are a product of our environment" (4)	Social	1,3, 4, 6	Typical
		"No, the devil didn't make you do it. Some stuff you did" (5)	Personal Choices	5, 2, 7	Variant
		"I think it's a combination of all of it" (2)	Complex	2, 5	Variant

In general, participants indicated that they were confronted with mental health issues frequently, with most pastors saying they addressed mental health issues among their parishioners every day. Half of the participants specified the specific types of mental health issues that they attended to as pastor. Only a few pastors spoke specifically about their behavioral responses, rather giving their beliefs about coping, which may be indicative of their behavioral responses in those situations. For this study, ideas about coping and behavioral responses were considered as separate categories.

When asked about coping with mental health issues, all eight participants indicated that causes were complex and could be various combinations of biological, spiritual, psychological, and social spheres of influence. In general, participants differentiated between adaptive and maladaptive coping mechanisms, although this was

not limited to adaptive and maladaptive religious coping styles. Some participants noted distinguishing characteristics of African Americans that could influence the coping process. Specifically, half of the participants noted a historical influence as important to African Americans' experience with mental health issues. Participants also generally had positive experiences with mental health care providers in their community, although about half of the participants also noted negative experiences as well. Also, six of the participants mentioned an idea of parishioner pain and growth, emphasizing congregation members' personal development over time. In the following section, the author will discuss domains, core ideas, and categories from the data. Additionally, the author will include words directly from the participants.

Domains, Core Ideas, and Categories

Six domains emerged through the analysis process by the research team. The domains include: (a) frequency/type of mental health issues, (b) causes of mental health issues, (c) coping with mental health issues, (d) perspectives on mental health services, (e) African American experience, and (f) on being a pastor. The categories and core ideas included in each domain also are discussed in the remainder of the chapter.

Frequency/Type of Mental Health Issues

In this first domain, all of the participants indicated the frequency that congregation members with mental health issues approached them. Additionally, participants typically identified specific types of mental health issues they often see in their local congregations.

Frequency. All the participants responded that they were confronted with mental health issues often in their religious communities. In fact, 7 out of 8 of the participants noted they dealt with various mental health issues in their congregations every day. As Participant 2 indicated, "Yeah just about every day of the week. I deal with one of those issues every day whether it's a phone call or a counseling session, or just an office visit. But just about every day, I deal with them." Participants also shared that they dealt with these issues both informally and formally. Participant 5 added,

> Informally, via text or phone call or voice mail, there's certainly something every day. But formally, I try to limit counseling to a couple of times a week and no more than maybe two or three a day, more like two, because just the psychology of listening to somebody's pain on the counselor is huge.

Some of the participants also added that these issues were not necessarily initiated by the parishioners, and often times they are manifested in more implicit rather than explicit methods. Participant 8 stated, "Every day. Every day. You see it every day. The biblical or the spiritual term of things is called discernment . . . You hear it in the testimony".

Type. Along with frequency, five of the participants devoted time to specifying the various types of mental health issues they see. Participant 2 stated, "I've dealt with my tenure here, people with schizophrenia, paranoid schizophrenia, autism, and those types of issues. But depression and anxiety are the ones that hit us the most." Participant 3 added that contextual factors could influence the types of issues she is faced with as a pastor saying,

> Actually, we just of course, went through the transition of you know, the economic crisis, and so many people in the congregation lost their jobs. It's like

> even though we're a small ministry, it's still affected us. So yeah, I see people on a regular basis with those challenges.

Further, Participant 5 added that he sees, "abuse, domestic violence, addictions, just general advice." It seems that participants see a wide range of issues and although the responses could imply that most interactions with congregants are when they are in distress, Participant 5 adds, "Some folks occasionally come by to say 'You know what? I don't have anything to complain about. I am just happy.'"

Additionally, some participants referenced mental health issues or distress experienced by congregation members as "going through" rather than using more clinical language (i.e., depression, anxiety). Participant 1 stated, "There's someone in the congregation all the time that is going through. That's what we call it. Going through. And then there's someone that's going through don't even know they're going through." Participant 6 recalled a time when a congregation member was "going through" saying,

> Somebody was "going through" and needed a break financially and I set down a scripture. I think its Psalms 37:25 where it says, 'I never seen the righteous forsaken nor his seed begging bread.' God will never forsake you, no matter what it look like. He is with us. Hold On. Your change coming.

Causes of Mental Health

Most often, it seemed that participants typically spoke about spiritual and social causes of mental health issues, focusing on the importance of relationships both with God and fellow human beings. There were no general responses in this domain; rather, categories were either *typical* or *variant*. Other causes that were discussed included the idea of personal choice, social factors, and psychological factors and are included below

as categories. Complex contributors and biological influences were most rarely discussed and are considered variant categories. Only one participant mentioned biological factors as a distinct contributor to mental health issues. When other participants mentioned biological factors, they were included as a part of other spheres of influence (i.e. spiritual) and were included in the complex category.

Personal choice. Although a variant response, 3 of the participants indicated that mental health issues were caused by one's own personal choices. Participant 2 spoke about choices trumping other spheres of influence saying, "I mean I believe they (biological factors) exist but again there are choices that are involved in us making necessary things to keep it from affecting us the way it does sometimes." Similarly Participant 5 stated, "The whole Flip Wilson, 'The devil made do it.' No the devil didn't make you do it. Some stuff you did."

Social. Typically, participants named social spheres of influence as contributing factors to mental health issues. When participants mentioned social spheres of influence as contributors to mental health issues, there seemed to be an emphasis on relationships and how people try to adapt to external societal expectations as well as family and friends. When speaking about difficulties with parenting, Participant 1 stated

> And parenting, I don't know, today in the modern day, I don't know. I don't call it love. I call it selfishness. When parents are willing to do what it takes to get their children in the right state of mind, or to obey. I'm from the old school when it comes down to that. I know I'm from the old school. But I don't believe parents should let children say anything to them.

Other participants elaborated on societal expectations and the response of many parishioners that led them to experience distress, including anxiety and/or depression. Participant 3 noted, "So society puts all kinds of you know, stipulations on what we ought to be doing when no, you make your own life. So I believe that's why we're so depressed so much, and anxiety takes place."

Participants noted the effect that relationships with family and friends can have on one's mental health. Participant 3 acknowledged social factors as environmental influences offering, "We are a product of our environment. A lot of our things come were passed down from one family to another. Sometimes I think it could be association." He goes on to say, "I have over the years, a lot of things is passed down from one generation to the next until you come into the knowledge of truth." Participant 6 identified isolation and lack of social support as a primary reason that people suffer depression. He indicated a need for people to encourage one another citing,

> You get hit with everyday life, you know? I don't think we encourage each other enough. I don't think we tell each other we can make it enough. It's gonna be all right. I've been there before. You don't know my story because when we're going through a moment we feel like we don't want anything, nobody, never. I was reading scripture out of Ecclesiastes 1:9 today, it's funny. There's nothing new under the sun. Everybody been through some things, just different times and different season you live long enough, you met somebody been through what you been through.

Spiritual. Spiritual causes of anxiety and depression was a typical response, and the most frequently offered cause. It seemed that participants spoke about spiritual causes originating in one's mind, likening it to an attack of sorts from the "enemy". For

clarification purposes, the "enemy" is used to reference the devil in many of the participant's responses. Participant 1 stated,

> One of the greatest stress or mental health is fear. That's what the enemy uses. That's his number one weapon. That's his number one key. That's his number one everything that he uses to defeat us. He uses it to take away our confidence. People are afraid of what might happen. And that's why salvation is so great because salvation runs on faith. Destruction runs on fear. Satan uses fear like God uses faith.

Similarly, Participant 5 added,

> You start thinking about anxiety and depression and you start thinking about the mind and therefore, you start thinking about the soul. And certainly there is a spiritual battle that's waging. The enemy comes at people by way of a thought and it's a serious assault.

Some of the participants spoke about the person's role in the spiritual aspect influencing anxiety and depression. For example, Participant 6 stated, "Because they have a lack of faith in God because it's gonna work out. What's gonna happen, gonna happen. What's gonna be, gonna be." Participant 7 spoke about the consequences of not including the spiritual tenet which could consequently result in distress, saying, ". . . but I'm convinced that often times when we haven't elected the spiritual tenet or part of it, it brings on the other physical." He went on to say, "I think so many folks have forgotten the spiritual aspect and forgotten that we are body, spirit, and soul rather than just physical."

Psychological. Only two participants identified psychological factors as a specific cause to developing anxiety and depression. When Participants 1 and 3 spoke about

psychological factors, they both named lack of self-esteem as an influential factor in one suffering from depression and anxiety. Specifically, Participant 1 named, "lack of confidence" as a cause saying that low self-esteem kept people from working towards different goals and thus spiraling them in a state of depression or anxiety. Participant 3 stated, "I believe that a lot of times it's caused by feelings of inadequacy. Not feeling like you are able to, you know, complete something."

Complex. While not a general or typical response, complex causes of mental health issues did emerge in the data from two participants. Complex causes indicated some integration of two or more of the other factors (i.e. social, psychological, biological, spiritual). In the next domain, complex coping will be discussed further as it was a typical response. Participant 2 stated,

> I think it's a combination of all of it. I mean when you sit down and just get to the lowest common denominator it's a combination of all of those things cause one bounces off. We're not totally spiritual; we're not totally psychological. We're all of this.

Further, Participant 5 spoke about instituting a panel at his church that would address the "biological, the spiritual, the social aspect of what life is."

Biological. Participant 5 was the sole participant who delineated biological factors as a contributor apart from other causes (i.e., spiritual, psychological, social). Other participants included biological factors with other contributors and therefore were categorized as complex. For example, Participant 5 stated, "Well, surely it is. The devil is busy and if you drink after somebody that has bronchitis, so biological right, that doesn't mean I'm not saved."

Coping with Mental Health

In this third domain, participants discussed their beliefs about various ways to cope with mental health issues such as anxiety, depression, bereavement, financial issues, and familial (i.e., relationship and parenting) issues. Participants identified spiritual, psychological, social, and complex forms of coping. As with the *Causes of Mental Health* domain*,* the factors will be discussed independently when participants spoke about them independent of other coping methods. When coping methods were discussed in conjunction with one another, the research team grouped them in the complex category. Participants also differentiated between adaptive and maladaptive forms of coping. Two other categories emerged in the data including a typical response of avoidance as a coping mechanism and a variant idea of personal responsibility of the congregation member in the coping process.

Spiritual. Typically, the participants named spiritual forms of coping as an independent, appropriate form of coping. Participant 1 stated, "Because many times according to facts, according to what we see, hear, or feel, (it's) total loss. But when we believe our God and the word of God which is inseparable, you can't separate God from his word – when we believe what God has to say over a situation, it changes". Participant 1 goes further when comparing forms of coping stating, "The only foolproof plan I know is the plan of God. Because you cannot work God's plan and fail. So, a good key to that is if you're failing you need to back up." Participant 3 noted that life would not be without challenges, some that often lead to experiences of anxiety and depression but that spiritual coping could help make life manageable.

> When I think about it, I believe that the Word is truth. I believe that when we make the decision to make it applicable to our lives, and we can walk it out, not without challenges though, because there's going to be challenges all the time. As a matter of fact, the scripture says that many are the afflictions of the righteous, but God has delivered us out of them all. So that lets me know right there then, I'm not going to live a life free from challenges and free from you know, pain, and all types of things. It's just the way I handle it and the way I deal with it.

There seemed to be a sense from the participants that even when other forms of coping were endorsed, spiritual coping seemed to be foundational and primary. Participant 1 stated, "Spiritual coping is more effective when God is used as the first and primary source, rather than an after-thought or back-up plan." Participants also seemed to rely a great deal on biblical support when speaking about spiritual coping. Participant 6 stated,

> I go to the word. The word says be anxious for nothing, but in all things with thanksgiving and supplication and prayer, make your requests known to God. God knows what you need. Participants endorsed other forms of spiritual coping in addition to scripture including, prayer and praise.

Participant 8 stated, "Prayer really brings results."

Psychological. Only two of the eight participants noted psychological coping methods as an independent means of coping. When other participants spoke about psychological forms of coping it was in combination with other coping methods (i.e. spiritual, biological, social) and these will be discussed in the complex category.

Participant 3 stated,

> But to have a one-on-one session with a professional counselor, it's going to benefit you if that counselor is sensitive to you know, to your background and

> things like that. Now if it's a matter where you don't – I'm just here, you might run into some problems. But I just believe good solid counseling is a good thing.

In this statement, Participant 3 seems to value counseling, but specifies counselor characteristics and responsibilities to make the session effective. Participant 3 indicated that the counselor must be sensitive to the background of the client in order for psychological coping to be considered effective. Participant 5 spoke about the importance of normalizing a person's experience while demonstrating empathy. In the following quote Participant 5 is specifically speaking about how to cope with bereavement.

> Sometimes no one needs you to say anything but just really empathize in that situation and then quickly begin to be a person that helps you understand how normal grief is and how necessary grief is and how grief is a process and begin to help them walk through that way past the funeral, especially past the funeral, when they really, really begin to get this place of no family, no visitors, and my mind is reminding me of the person I just lost and helping them understand if I'm angry, it's okay. I'm scared, I'm happy, I'm sad. You've got to get them through that process and helping them to understand, the African American Church, that Christian psychiatric help is okay. It's not taboo.

Complex. In general, participants felt that coping was complex and often involved an integrative approach in which multiple forms of coping (i.e. biological, psychological, spiritual, and social) were enacted together, rather than separately. All eight of the participants endorsed complex coping as appropriate when dealing with mental health concerns. In contrast to complex causes, complex approaches to coping seemed to be a more common response among participants. In other words, participants were more likely to identify a specific cause of anxiety and depression as spiritual, psychological, or social; however, they were more likely to offer an integrated approach

to coping with those issues, regardless of the hypothesized cause. Participant 4 stated, "Whichever one you may choose out of all the ones that you mentioned, maybe that could start a process maybe it can't complete the process. There was also a theme among some of the participants of getting to the "root cause" as mentioned by Participant 3. Finding this "root cause" seemed to involve various approaches and complex forms of coping.

Participants seemed to acknowledge the spiritual component as necessary but in many cases not sufficient for coping. Participant 3 stated,

> I can give you scripture, I can pray with you and things of that nature, but I've learned even in my personal life, because of one of my children had some issues, as so really to me, professional help is the answer. Now I like to couple that with the word of God if at all possible. But I've seen experiences where even that was just not- it didn't make sense. Especially when you're dealing with someone who has schizophrenia. And I've experienced that. So the word is not – it wasn't appropriate because they can't balance what's real and what's not real.

Similarly, Participant 6 stated,

> You can give them word all day long, but still the bottom line is how they feel, what they going through. The word can bring light to a situation but at the same time, you know, you gotta know is this right?

Later in the interview Participant 6 also stated, "I might have a spiritual tone to it but on the flip side there's some practical things we can use to help you out, too." Participant spoke about coupling teachings from the pulpit with other social coping mechanisms. He stated,

> So teaching a congregation God can heal, but you also need to seek help because when Jesus claims the lepers, all ten of them, the best thing about that is they could not commune amongst the rest of the people, but it was crazy because it was ten of them. They were together. You have to know that sometimes we have to have people come together. Everyone who suffers from depression needs to come together and then the church then needs to employ or bring somebody in to deal with those people that has that depression.

Similarly Participant 4 acknowledged the need for both spiritual and biological forms of coping stating,

> I like to believe that it takes both prayer and medicine to bring a balance. Don't throw away the God part and just say I'm going to perceive the social. I say bring the two together. Bring the two together. Let's get some balance to it. Let's use God and man to bring a balance, to bring a healing.

Adaptive coping. As mentioned earlier in this chapter, participants seemed to draw a distinction between adaptive and maladaptive forms of coping. Participant 2 recounted a particular example of when he saw the benefits of spiritual coping. In fact, he stated that it was difficult to choose just one.

> Wow, it's so many of them that we use choose religion to focus on. I guess I look at my kids, especially the kids that are in college. When they are anxious over exams now and they'll call and say 'you know Pastor, I prayed and I asked God to tell me the answer and I got an A on the exam and stuff and so it changed their mindset. It increased their faith, number one, and it brought them closer to God and they realized if I can pray and get an A in this class you know (I'm going to) try it again next time. So those types of issues. Not to mention just seeing people who have been diagnosed with cancer and we've seen God heal them from cancer several times and have watched their lives change as a result of that religious connection and that relationship with God and watching Him do what He does for them.

Participant 4 recalled a congregation member who had been struggling with depression and other self-destructive behaviors improve. Participant 4's daughter details the story below,

> We've known people very closely to like manic depression and she was a self-mutilator for many years. It was getting very bad, but her commitment to her spiritual life and equally her commitment to her better well being and taking her medication, equally seeing her psychologist, and equally being very honest with herself about what was causing her to self-mutilation, we have seen her come into a much more healthier person and she has stopped the self-mutilation and she's just a much more healthier person now that she has taken a total holistic approach to her well-being.

Participant 4 added that a crucial element of adaptive coping is giving people autonomy in their recovery process. Similarly, Participant 5 explained, "Not telling them what to do but pointing them to a good model that works, not saying that this is the only way but this is a way that worked."

Maladaptive coping. In general, participants noted that any form of coping in excess could be considered maladaptive. Many of the participants specifically referred to maladaptive forms of spiritual coping. Participant 7 stated,

> I think we overuse the spiritual when we don't face reality, when we come with this pious, 'Oh God gonna do it, hallelujah, praise God. Oh God, I know I was in trouble but God gonna do this' . . . I think it is acted out sometimes through emotional shouting and hollering and that's venting some of frustration and some of that depression.

He went on to tell an example of a member who he felt had used maladaptive coping recalling,

> Another example that I can think of a lady whose daughter passed away suddenly and unexpectedly in her late adolescence, as I understand it never got any kind of counseling and she just clings to the church but it was just spirituality over a lot of anger and bitterness that she was holding I'm assuming against God and anybody else that came in. And that's the part I think when we talk about the spiritual part when you have not dealt with the anger and bitterness and try to cover it with spirituality, you've got a mess.

Other participants also spoke about using praise and spiritual practices as a means to avoid confronting issues, which typically results in maladaptive forms of coping. Participant 8 explained,

> I do believe people shout too much; I do. Now I'm one who will shout all day long. But I believe that we don't –we shout over problems, and if you have a shallow foundation, you shout over it, you're gonna fall through. I think people need to understand where shouting and dancing really came from.

Maladaptive spiritual forms of coping were not the only type mentioned by participants. Other forms of maladaptive coping included biological coping methods, such as using prescribed medication as well as forms of self-medication to cope with pain. Many participants warned of the negative side-effects of overusing or misusing medicine as a coping. Participant 2 elaborated by saying,

> We can over-rely as well as under-rely. You know it goes back to the level of depression or the level of anxiety, dealing with kids in the school system it especially those with hyperactivity disorder you got parents who refuse to put them on medication when the medication would help them. But then you got some parents who want to pump it in them all the time. And I mean, it's the same way with adults. You know, we tend to wanna drown out our issues with medication, painkillers. I've dealt with substance abuse as far as that concerns. Alcohol, you know something, whatever. We overdo things to try to hide what's really there. And then you've got some who really are in denial who need to be on medication.

Akin to Participant 2's thoughts were Participant 3's words concerning maladaptive coping, namely referring to medication, saying, "But I also believe that the medical profession needs to be very, very careful in over medicating people. I've seen it too many times. I've seen it right here in my congregation."

Avoidance. Participants seemed to specify avoidance as a particular form of maladaptive coping and thus the research team considered it a distinct category. Avoidance seemed to not only show up with individuals but some participants equated avoidance as a coping style that is common among African American people. Based upon the participants' statements, it seems that avoidance is a coping method, which could result in a state of anxiety or depression. Based on consensus from the research team, though, avoidance was categorized under the coping domain rather than the causes domain. All of the participants who discussed avoidance seemed to consider it an unfavorable form of coping that they did not endorse or encourage among their congregants. Avoidance is considered a typical category with five of the eight participants speaking about it. Participant 2 stated, "You got some that their families are suggesting that they get counseling and they refuse to do it or they go one time and won't go back again because something is said that they didn't want to hear". Participant 4 stated,

> I think moving, a fast-paced life. You don't deal with it right then. You set it aside and it builds, and I've found that within myself, not dealing with something right then, it causes a lot of anxiety and a lot of depression because we wanna just act like it did not happen, that divorce or that relationship, and relationship-wise that's a lot of the problem. You get out of one and straight into the next one, and so you bring that with you. You never handle what's right there.

Participant 7 also discussed the issue of avoidance as a coping strategy he has seen in his congregation stating, "The most times, the present depression that I be dealing with and that I counsel with is because of some past event, traumatic or shattering experience that they haven't dealt with and they have now begin to culminate and begin to get bigger."

Personal responsibility. Only three participants spoke about personal responsibility in coping and thus it is considered a variant category. However, it is discussed in this chapter because the three who spoke about personal responsibility spoke about it in response to coping with financial concerns. There seemed to be a specific emphasis on the person's role in successfully coping with and recovering from financial constraints or unemployment. When asked about coping with financial concerns Participant 1 responded,

> It does not take all your money, it does not. And once you get in the habit of saying okay, you'd be about like a company. You've heard a company say well, we didn't do that good this year. That don't mean they didn't make money. They just didn't make their goal. Maybe they wanted to make $40 million, and they didn't make but $20 million. But they didn't go in the hole. You know what I'm saying? Their projection. But the reason why the doors are open is because they won't let themselves get but so far. But you've got households; they spend every dime they got. And I love to see, to get people to stop that.

Comparably, Participant 3 spoke about a specific member in her church who she believed had successfully coped with a financial crisis when she faced unemployment. Participant 3 seemed to focus on the person's response to the situation saying, "And my best advice you know, just take the time to reinvent yourself, and do something. Maybe you've got to do something different that you're not used to doing."

Personal experiences. All ten of the participants spoke about their own personal experiences with anxiety and depression, describing times in their lives where they have struggled with worrying or feeling depressed. Only one of the participants, Participant 4, stated that he had never worried in his entire life. He expounded:

> To be honest with you, never had a headache in my life. I don't worry. I don't fret. No. I think two of the things is number one, I'm not a revenger. I don't hold on to revenge. I'm quick to forgive. I'm quick to put it behind me. I keep a merry heart and I learned to trust God. So again, I don't have a lot of experiences a lot of pastors have. I don't worry. This is a big ship here, trust me. This is a big ship. A ship this big you could worry a lot, but my philosophy is if God can handle it, I sure can. So I've learned to just depend on God. I'll be honest with you, this is God's truth, I don't have bad days. I don't worry. I don't have headaches and things like that. I could if I worried a lot, gave into anxiety, but that's a state of decision. I've learned to trust God and I totally depend upon God's word. He says, 'Be anxious for nothing'. So that's it. Read it. Philippians 4:6, 'Be anxious for nothing.'

Conversely, his daughter described her experience as different from his and spoke about times in her life where she had dealt with anxiety and depression. She stated:

> And now to speak as a daughter, and seriously I've experienced both, and that's why I'm such a large proponent of counseling. Through counseling and through the Word of God, I have come a very healthy woman, and that to no level of denial, but that's to the true inner knowing. When you experience it you know it, and when you're done, you're done.
>
> That's why I say I'm a very strong proponent of counseling and sometimes as my dad said you need a mediator, but equally you really need a clear understanding that God understands what you are going through, and I'll say through my experience that it really helped me to see that the Bible addressed a lot of mental issues. So that's where I'm such a strong proponent of counseling plus the spiritual aspect, because if it would have just been counseling I would have literally just be popping pills and just mad and blaming and all that, but through true Godly counseling therapy and the Word of God, it has made me a much healthier woman.

Additionally, the participants described their own personal coping strategies which primarily involved social and spiritual supports. Participant 2 explained it as:

> Prayer! Prayer, prayer, prayer. I have to pray. Sometimes, you have to have an outlet. I work out, I exercise for my outlet to deal with it. Just hanging out with friends who are not as spiritual, who can let you be you and stuff you can bounce things off of, that you can talk to. Having that network of people . . . You have to have that network of people to allow you to be you and to vent sometimes.

Additionally, some of the participants spoke about time restrictions on the amount of time they allowed themselves to stay in feelings of anxiety or depression. Participant 1 described:

> . . . how well you know your source. I'm not down long, because of this. Now I think it's like they do machines there. If you don't do the thing that recharges that up, you know, it's just not going to work properly. It's just easy for it to catch a cold.
>
> I can't stay down a day. You can't do that. My wife and I, we don't agree on everything, but we refuse to be upset at one another. Because when you get down and you get out of God's way he says to do things, then the enemy has the right to come and tear up stuff. I believe that. So I refuse to be down.

There seemed to be a theme among participants that the role of pastor is taxing, and they often neglect their own personal wellness in caring for members of their congregation. Participant 3 stated, "And we're the worst. Pastors are the worst. We don't rest. You know?" Similarly Participant 5 explained:

> Yeah, I think that if any pastor says that they don't experience a level of anxiety, shoot, even Jesus had, on a regular basis, to steal away to the mountain by himself and pray and that's the recipe, the prescription, to help deal with the pressure or the anxiety that comes along with the vocations. So I think that those who have a way to deal with it very unapologetically.

Perspectives on Mental Health Services

In this domain, participants spoke about their perspectives on the mental health delivery systems in their communities. The participants spoke about some personal experiences, either with them or their family members, as well as experiences they learned from congregation members. Two primary categories emerged from this domain, positive experiences and negative experiences.

Positive experiences. In general, the participants noted positive experiences with mental health care providers in their community. Participants seemed to also think highly of professionals with whom they had personal connections, like Participant 7 who talked about his wife and Participant 2 who spoke about helping professionals within his congregation. Participant 7 described his experiences with mental health professionals as limited, but overall positive. He stated, "And I have a very limited experience with them and I think probably the most I've had was about my wife being a professional counselor. I have seen some very, very positive results of her dealing with young ladies in marriage situations and helping them to sort out their relation." Participant 1 stated, "There are many organizations where no one is saved, but they do have a heart for the people." Participant 2 seemed to value the way in which helping professionals provided consistent services to his congregation members saying,

> It's just seeing them embrace the people and actually sticking with them to the end until they've found the help that they needed, until they realize that their meds were regulating and it worked for them as opposed to against them. That's the positive side, just sitting back and watching the social workers in the congregation and the helping professionals in the congregation just stick with that person and them feeling like they're not in that situation by themselves.

Participant 6 also seemed to emphasize the characteristics of the professional as being important in his perspective explaining,

> The ones I know they care about the people. It ain't about the job, it ain't about the money involved in that but I think they really try to help them. The people I've come in contact with, it's like they got a kind heart about what they do. It's a passion, not a job.

Negative experiences. Fewer participants talked about negative experiences with mental health service providers, forming a typical category. Participant 5 said that he had not had any negative experiences with mental health care providers. He explained, "That's not to say they're not out there, but I have not." Just as characteristics of helping professionals seemed to be important in positive experiences, they also seemed to matter to the participants when speaking about negative experiences. Participant 6 expounded by saying, "Some people just want to put everybody in the same boat." Similarly Participant 8 recalled an experience saying,

> Gotta know who to send people to. Some places you cannot send people Because of the lack of empathy that the workers provide. It's sad, but most of the people who help people need help, but they have to do it. I say all the time you're preaching, but you need somebody to preach to you. Some places I will not send people because the negative feedback that I hear from people. We were trying to find a young lady a home because she was in a bad situation and we needed to get all the paperwork and all of this stuff, which I understood, because that's the law. They needed that. We sent an individual down there and the person was so nasty to them that I then went down there, spoke to the manager and everything, and then I submitted a letter to the corporate office.

African American Experience

In this domain, participants talked about the African American experience as one that is unique from other racial and ethnic populations. Participants noted how pastoring African Americans is different and requires an understanding of the history and the mindset of that specific population. History and stigma emerged as typical categories within this domain. Contrast emerged as a more variant category and will be discussed below.

History. Typically, participants seemed to note the unique historical experience of African Americans and the Black Church as important and influential in their role as pastors. Participant 5 described the black church saying,

> And then when we define the African American church, of course the Christian church is really red in terms of the blood of Christ and there is no designation between race but the institution of the African American church is necessary and real for three reasons. One, it was the place where people could come and organize, 'cause no one would give them a place, so the church, the African American church, became that place. Number two; it became the place where you could actually dream. You could come and express the passion that you had and have a platform for that. That was huge. And the third reason, there's still I think a lot today, waning some but still pretty prevalent and the third reason is leadership. You had folks that did not have any time of leadership position in their secular life but in the black church, the African American Church, they could be elders. They could be deacons. They could be pastors. They could be mothers of the church and accept leadership roles. So I think that's important to actually frame what we're talking about.

Participant 6 described the history of African Americans as a challenge he faces when pastoring. He revealed,

> I would say it's difficult because you've got so much history. When you're dealing with African American people, a lot of them over the years are bringing

> the history into the Christianity. And what I mean by that is that we have to be untaught. We've been taught we won't be nothing, can't have nothing, where we come from instead of a Biblical perspective.

Participant 6 further elaborated on this history and the consequential struggles that African Americans have had to face and how it has shaped their perspective on suffering and coping styles. He expressed, "That's just our makeup. We're enduring creatures. I would call it. We can endure."

Stigma. Participants also spoke about the stigma that is often associated with seeking help, specifically for mental health issues, within the African American community. When participants spoke about stigma it seemed to be on a global, rather than individual level. In other words, avoidance seemed to be more intrinsically motivated and stigma seemed to be externally motivated, with African Americans as a whole facing stigma. Participant 5 described this stigma as such,

> The taboo for African Americans that think this somehow is a strike against my humanity to struggle from a mental health perspective and the decades of silence that I live and the generational silence that is in place that if we knew, we could curb this. There's a lot of things other than shock treatment or whatever you think that can help sustain you from a mental health perspective and I think that we are seeing evidence of lots of mental health issues with a lot of the suicides that are happening.

Similarly Participant 7 stated, "As a people, we have just not reached a point of understanding the importance of the professional mental health." Participant 4's daughter also talked about the difficulty in combating the stigma that often is associated with seeking help saying,

> And equally just helping particularly with Black Americans, the mental health issues, equally counseling, is not it does not have the stigma that we sometimes associate with it. That can be the difficult part in helping them to really understand that sometimes there's many things that contribute to it, and the possibility of it into why you may need additional help… you may need to take this a step further, but it can be challenging having to be the bearer of the news to show you need additional help beyond, and sometimes even to the place, like I say in working with young people, even to the place that looking at medication as not to what we have stereotyped it to be but that can be the difficulty of having to relay that information.

Contrast. Three of the participants, considered variant, spoke about African Americans as being different from other racial/ethnic groups, comparing them to the majority Caucasian culture. The participants spoke about this difference as not only having implications for African American's mental health and treatment, but leading to misunderstandings about behavior and culture. Participant 4 stated,

> And that is a thin line there, 'cause I know of cases where children have been – how do I say this? Black children react different from white children mainly because of the culture that we're raised in. Their learning patterns is different, and I know with some Black children that was put in a white environment but the teachers could not relate to their learning skills. So automatically the teachers wanna put them on (Ritalin).

Further, Participant 6 contrasted the coping styles of African Americans with coping styles of Caucasians saying, " The other color, not being racist. They lose their jobs, they kill themselves. We lose our jobs, we're like, 'Fine. Find another one. Whatever.'" Participant 6 seemed to insinuate that African Americans were accustomed to struggle and therefore are often not as quick to resort to suicide but also not as readily amenable to seeking help for issues that are considered common and, at times, expected.

On Being a Pastor

Complex roles. Three of the participants spoke about the complex roles that are expected from pastors, and thus the research team labeled this category as variant. Participant 1 spoke about the expectations that are placed upon him by his congregation, stating that at times it surprises him the roles that people assume he is qualified to handle. He described it as,

> You know, because it kind of fascinates us. You know, but I know that the Lord himself raises us up for the occasion. I don't believe if they were to ask us, I don't believe no one would come in and would really need help, I don't believe it wouldn't be available. I believe by them coming, you know, and making a request for certain things, and you'd be shocked at the kind of things that people ask. And you want to say, 'who do you think I am?' You know, but you do your best.

Similarly, even though Participant 2 is not a father he described fulfilling the role of surrogate father to members in his church stating,

> I've become a surrogate father to a lot of kids, a lot of teens, especially those with the population, some of the population being college students, that are away from home and away from their parents I have become a surrogate father, a lot of them attach themselves to other members of the church, other older people who are here . . .

The participants seemed to suggest that although the roles can be challenging at times, they are often rewarding. The roles that these participants have been asked to fulfill also could speak to the needs that are prevalent in the African American community and the specific congregations they pastor.

Black Church. Three of the participants spoke about how pastoring a Black Church was a unique experience, affecting their pastoral approaches and influence. The

uniqueness of the African American community was discussed earlier in this chapter and this discussion will focus exclusively on the distinctiveness of the Black Church. Participant 5 expounded by saying,

> I think for the Black Church, the pastor is the president in so many respects, in terms of influence. The president is the most powerful person. The president of the United States, no matter who he- and maybe one day she is – is the most powerful person on the planet. Power is influence. Influence is the ability to get somebody to do what you want them to do. Now whether you're Hitler or Jesus , they both had it. And so if they see you, and I think many African American churches do see their pastor as powerful influencer, what you say is going to take them in a certain direction.

Participants shared some of the challenges in specifically pastoring a Black Church. Participant 3 stated, "And I believe that really – and I can say this for the Black Church, we're not as exposed to you know, the worldview, the biblical worldview, as a lot of churches."

Resources. In general, pastors spoke about utilizing resources, both within the church and outside the church, as a part of their response to congregation members in need. Participant 8 spoke highly about what mental health professionals had to offer saying, "God has put mental health people there in our presence that they might assist us as ministers. When participants spoke about referrals outside of the church they seemed to advocate for Christian counselors as potential resources. There seemed to be a sense of trust in Christian counselors. Participant 4's daughter stated, "So I know for us as a Christian based organization we strongly encourage Christian counseling because we feel that you have very good license, very good psychologists but who would equally give

you the spiritual application to help you." Similarly, Participant 5 seemed to prefer a Christian counselor saying,

> Would I refer someone to a non-Christian-based psychiatrist or counselor? Probably not. That would not be my first choice. My first choice would be a Christian psychiatrist and my second choice would be someone that was just purely secular. Why? When I say write prescriptions, I'm not trying to say drugs, but their prescription could also be their methodology, their belief system. It's totally different. Someone non-Christian could write the prescription for Zoloft but the difference will be the other side of the prescription for in terms of what has happened and what they should do. That's very important.

Participant 2 spoke about attempting to meet parishioner's' needs within the church first and then outsourcing if the resources within the church were not available.

> Sometimes as a result we are outsourcing again only because we feel like we've done what we need to do. We can only take it so far and be held accountable for what we do unless there is someone in the church that is a licensed professional then we will outsource them to someone else.

Other participants spoke about recognizing their limitations when providing services and thus finding qualified individuals to attend to congregants' need. Participant 4 described his experiences when reaching his limitations as,

> So I kind of draw the line there when someone come in here that I feel full of anxiety they're stressed out, and I like to send them. I like to pray with them but also send them to get some medical help so they won't come up short.

Some of the participants spoke about referring congregants when they felt as if the presenting concern was outside of the realm of competence. Participant 6 explained,

> I mean, I had people come in that was on drugs, alcohol. Sit them down just so I can send them somewhere. I can't deal with that. I ain't never been a drug addict, so I can't really deal with something like that experience.

Similarly, Participant 7 spoke about his limitations in working with congregants. He described a parishioner who lost her child and he felt that she needed additional support. He stated,

> That is one that I must confess that I perhaps have not done a good job in really focusing in on that need. But I can say I see myself more or less as a general practitioner and I realize my limitations and my ability. And there have been cases that come to me where, say for instance, the death of a child. A young lady . . . I recommended that they go to a counselor, a person who has biblical training and secular training, because I just felt I was inadequate. And that is pretty much my approach on many of these issues that I feel is just over my expertise of training. I try to recommend or suggest that they go somewhere.

Development. Six of the eight participants cited growth and development of their congregation members as highlights of their ministry and rewards of pastoring. It seemed that many of the participants observe parishioners in some sort of emotional pain, and through the ministry were able to overcome their distress. Participants seemed to take pride in witnessing their congregants' growth. Participant 3 elaborated:

> Wow. Some of the highlights. For me, it's really been just growing the people. Seeing people's lives transformed. Not without you know, challenges. But just seeing people come in and have that first experience, that first encounter. Or even some people who come in who already know Jesus as their savior, but they have real serious life challenges. And just being able to minister and mentor people to a place of wholeness. That's been rewarding for me.
>
> Well really, I believe that life in itself doesn't come without challenges, and that's constant. Okay? But what I believe is considered to be wholeness is when you can not only take the word of God and apply it to your life, but also have the

> influence of people, mentorship, you know, good health choices. Things like that. Being able to have a life plan. Set goals and things like that.

Similarly, Participant 5 explained:

> Growth, to see people grow, to see people mature, to see people be able to walk past things that they never thought they would be able to walk past, to see the overall church move in the direction of not a neat little hotel for the same folks week in and week out, year in and year out, but transform into a hospital for people who are sick. And the joy is although we move in extreme excellence, you're not afraid of the messiness of excellence, especially when you start to deal with people who are hurting. So those are some joys for me and of course you say winning souls, making disciples, clearly a significant piece

Summary

In conclusion, the research team found ten typical categories and seven general categories. Again, *typical* categories are those that emerged in 4-6 of the cases. *General* categories were those that emerged in 7-8 of the cases. The research team also found ten variant categories. The *variant* categories appeared in 1-3 of the cases. Table 3 lists all the general and typical categories.

Table 3. General and Typical Categories

General	Typical
Frequency	Type
Positive experiences	Stigma
Resources	History
Complex (coping)	Negative experiences
Adaptive coping	Spiritual (coping)
Maladaptive coping	Social (coping)
Personal experiences	Avoidance
	Spiritual (causes)
	Social (causes)
	Development

CHAPTER V

DISCUSSION

> So you have to know where to send people and at the same time there are a lot of good places. I'm glad that you're doing this because a lot of our people in the Black church do not feel comfortable with Caucasians or anybody, anyone else. So if they're going to someone and they sit there telling the people their problems, they really won't tell all of it because they feel like this person is out of touch, and a lot of people are out of touch because some of the people in those positions don't know or either they forgot. – Participant 8

Overview of the Chapter

In Chapter IV, the results from the qualitative investigation regarding pastoral responses to mental health needs of their congregation members were presented. In the following chapter, an overview of the study is provided, results from the investigation are discussed, and limitations of the study are noted. Further, implications for counselors and counselor educators are discussed and suggestions for areas of future research are offered.

Overview of the Study

Because of the under-utilization of mental health services within the African-American community (Avalon & Young, 2005), more research attention should be directed toward factors that affect the help-seeking behaviors of African Americans (U.S. Department of Health and Human Services, 2001). When African Americans have unmet mental health needs, they are less likely to attain an overall positive measure of health and well-being (U.S. Department of Health and Human Services, 2001), possibly

contributing, at least to some extent, to the social struggles in the African American community (Youman et al., 2010), including elevated levels of incarceration (Liptak 2008), substance abuse (U.S. Department of Health and Human Services, 2010), and poverty (U.S. Department of Health and Human Services, 2001). Stressors such as bereavement, familial issues and high rates of unemployment and economic disadvantage are likely to contribute to African Americans' experience of anxiety and depression; however, African Americans tend to seek professional counseling at a much lower rate than other racial and ethnic populations and instead turn to their spiritual leaders as a resource (Ayalon & Young, 2005). Accordingly, more careful attention should be directed toward the mental health issues, help-seeking behaviors, and various counseling services used by African Americans (U.S. Department of Health and Human Services, 2001).

Generally, the Black Church is considered a less stigmatized resource for seeking help in the Black community (Andrews et al., 2010), a solution for many mental health problems (Newhill & Harris, 2007), and pastors are valued as credible sources for assistance with social and psychological problems because of their status as pastor, often regardless of the pastor's educational background, knowledge of mental health issues, and previous experience (Kane & Greene, 2009). There remains much that is unknown, however, about pastoral motivations, beliefs, attitudes, and influence related to mental health needs of their parishioners. The fact that pastors have influence is well established. What is less clearly understood, though, is *how* they influence parishioners.

To date, researchers have not empirically examined the role of African American pastors in the mental health needs of their congregation members. Therefore, the purpose of this study was to investigate African American pastors' response to parishioners who are dealing with anxiety, depression, unemployment, bereavement, and familial concerns; their motivations to encourage or discourage help-seeking outside of the Black Church; their perspectives on secular counseling services in their community; their perspective on spiritual, biological, psychological, and social coping methods; and their beliefs about identifying and responding to maladaptive religious coping strategies.

Participants were African American pastors of predominately African American congregations. Each of the participants (n = 8) participated in semi-structured interviews conducted in person with the student researcher as the interviewer. Interview lengths ranged in time from 37 minutes to 1 hour and 15 minutes. Additionally participants completed demographic questionnaires that asked questions about age, relationship status, gender, years of experience, education, denomination, church membership, and organizational structures.

After the interviews were completed and transcribed, the author used guidelines of Consensual Qualitative Research (CQR) methodology to analyze the data. Using CQR, the research team organized the data into domains, core ideas, and categories. The categories were used as a part of cross analysis and labels were assigned based on frequency across the different cases. Because of the qualitative nature of the study, the researcher did not have pre-constructed hypotheses or postulations regarding directionality. Research questions and results are discussed in the following section.

Discussion of Research Questions

Six research questions were established to explore African American pastors' beliefs regarding etiology and treatment of mental health issues, namely anxiety, depression, bereavement, unemployment, and familial issues. The research questions also were developed to gain more information about the frequency with which pastors responded to these issues and how they responded when approached by congregation members. Additionally, the research questions investigated pastors' perspectives and experiences with mental health providers in their community. The research questions are listed below:

1. How often do African American pastors have congregation members disclose mental health issues, such as anxiety, depression, bereavement, unemployment, and relationship issues?
2. How do African American pastors respond (behaviorally) to congregation members who are seeking their counsel on issues related to anxiety, depression, bereavement, unemployment, and relationship and parenting concerns?
3. What factors influence African American pastors' decision on whether to refer members of their church to seek mental health services outside of the church?
4. How do African American pastors perceive mental health service delivery in their community?

5. Do African American pastors encourage religious coping behaviors that neglect or recognize biological, psychological, or social factors? Further, do they distinguish between adaptive and maladaptive religious coping?
6. How do African American pastors apportion anxiety and depression across biological, social, psychological, and spiritual spheres of influence?

Research Question 1

Participants were asked how often their congregation members approached them with mental health concerns. More specifically, participants were asked how often congregation members sought their help with anxiety, depression, bereavement, relationship issues, and financial concerns. All participants indicated that they saw congregants with these needs often, with the majority of participants specifying that this happens every day. Participants noted that this contact could be formal (i.e. counseling sessions) or informal (i.e., phone calls or texts). Participant 6 spoke about how members and others from the community contacted him. He stated:

> Really. Every day you get a phone call or my administrator. We get phone calls every day. People don't even come down to the church. They say, "I saw you on TV. Do y'all help with rent? Do you help with the light bill? Do you help with food?" I got a guy who called the other day. He said he called four or five churches and they couldn't help him with food. He called us and we're like, "We'll be there in ten minutes. You're not going hungry." That's just my motto. As a matter of fact if I have to come get you to Come get some food. Meet me at Wal-Mart somewhere. I'll bring it to you. So it's every day.

Typically, Participants noted that they regularly encountered concerns such as anxiety, depression, bereavement, unemployment, and familial concerns. Some participants also added other types of issues they encounter. Congregants' needs seemed to range from

primary needs (i.e. food, shelter) to diagnosable mental health concerns (i.e. schizophrenia). Participant 1 shared, "I've dealt with my tenure here, people with schizophrenia, paranoid schizophrenia autism and those types of issues. But depression and anxiety are the ones that hit us the most." It is clear, then, that the participants of this study see a broad range of mental health and psychological needs among congregants and others who seek their assistance, and that this is a virtually daily occurrence.

Research Question 2

Participants spoke about their role in providing support for members in distress (i.e., anxiety, depression, bereavement, unemployment, and relationship concerns) as well as their procedures in referring members to resources within and outside of the church. A few pastors indicated that their roles were complex and unique because they pastored in the Black Church. Participant 7 explained his procedures in invoking resources outside of the church. He stated:

> Yes, it has helped in me referring because I have seen the benefits that it would bring and I think this ought to go back to what I was saying earlier about it has affected me in that, again, I realize that there are some needs in the mental health field that spirituality perhaps is not the only solution. So that's when I'm quick to say "Maybe you need to go see Dr. So-and-so . . ."

Some of the participants provided examples of the specific ways in which they have provided support. Participant 4 spoke about he responded to congregation members who sought his guidance with bereavement. He stated:

> As always I start it off with prayer. I try to coach them, counsel them how to overcome that. I think to help anyone who's been going through a bereavement you've got to feel them. Sometimes if you can get them talking then sometimes

> people can answer their own problems. I try to show my concern, I care, and then again bereavement in itself can be a detriment if you don't pull it in. Sometimes you have to get medical help. I know a situation just recently happened here that this woman's husband died and she just took it to the extreme, but I understand that she's now getting medical help for it though.

In the end, participants described complex behavioral responses that were somewhat varied, but which took into account the unique needs of each person. With some consistency, pastors spoke of working within their scope of expertise (primarily spiritual but also practical guidance) and relying on additional resources, both within and outside the church, as needed.

Research Question 3

Research question 3 aimed to learn more about the factors that are involved in pastors making decisions regarding members seeking services outside of the church. Participants spoke at great length about the African American experience, specifically with mental health, and the effect that stigma and history had on help-seeking behaviors, specifically with resources outside of the pastor and church. It seems that these factors may influence and challenge pastors' referral processes. For example, stigma was noted as a primary barrier as captured by Participant 5 who said, "The taboo for African Americans that think this is somehow a strike against my humanity to struggle from a mental health perspective . . ." Similarly, Participant 7 added,

> As a people we have not reached a point of understanding the importance of the professional mental health. We kind of feel that I got to do this or got to do that but God has put mental health people there in our presence that they might assist us as ministers.

This idea of stigma seemed to relate to the history of African Americans. Again, Participant 7 noted the historical influences saying, "I really believe that we as a race of people just never had the teaching, the experience of getting professional help for our situation." Similarly Participant 6 explained that African American history posed a challenge in his pastoring. He stated,

> I would say that it's difficult because you've got so much history. When you're dealing with African American people, a lot of them over the years are bringing the history into the Christianity. And what I mean by that is that we have to be untaught. We've been taught we won't be nothing, can't have nothing, where we come instead of from a Biblical perspective.

It seems clear, also, that pastors see a contrast between African Americans and other racial/ethnic population and that these differences influence presentation, coping, and treatment recommendations. Participant 4 stated,

> Black children react different from white children mainly because of the culture that we're raised in. Their learning patterns is different, and I know with some Black children that was put in a white environment but the teachers could not relate to their learning skills.

Research Question 4

Research question 4 explored participants' experiences and perceptions of formal mental health care providers in their surrounding areas. During the interview, participants were asked to speak about positive and negative experiences with professional care providers. All eight participants noted positive experiences with professional mental health care service providers in their community. When asked about negative experiences with mental health care providers, Participant 4 responded, "I have not. That's not to say

they're not out there, but I have not." Similarly, Participant 7 explained, "Any negative experience? I cannot pull one up off the top of my head. I'm sure there's some but I can't think of it." It was noteworthy, then, that some participants did not have negative experiences with the mental health service delivery system or, if they did, it was not so salient that the memories were accessible.

At the same time, five participants noted less pleasant experiences. Participants' recollections of more negative experiences involved lack of continuity of care, misappropriation of medication, lack of attention to uniqueness of client's presenting concern, and lack of empathy towards clients. These latter experiences (medication, lack of attention, lack of empathy) are noteworthy because they were contextualized as the mental health service delivery system not being responsive to the uniqueness of the African American experience. The participants in the study went to some length to describe the unique needs of African American people and a substantial number of participants reported previous occasions. where the mental health system had failed to respond to this uniqueness, in their experience.

Research Question 5

This research question explored the participants' attitudes towards coping with mental health. The question was intended to discover the participants' role in encouraging different styles of coping with their congregation members. Generally, participants suggested that coping is complex, involving a combination of biological, psychological, social, and spiritual methods. Different participants had varying blends of complex coping. Participant 4 explained:

> Whichever one you may choose out of all the ones you that you mentioned, maybe that could start a process; maybe it can't complete the process. It's obvious that if you continue doing one thing and never see a complete answer to what you're doing, it's obvious that you may need to go do something else.

Typically, participants also named social and spiritual coping forms as suitable forms of coping, which they encouraged among their parishioners. Conversely, typically participants stated that they often discouraged avoidant coping strategies among their congregation members. Three participants seemed to encourage personal responsibility in coping. Two participants specifically named psychological methods of coping as appropriate in healing. Generally, participants also added their personal experiences with coping with anxiety and depression. In their personal lives, participants also seemed to rely heavily on spiritual and social forms of coping. Only one participant stated that he had never experienced anxiety or depression.

Further, the research question was intended to investigate if pastors differentiated between adaptive and maladaptive forms of coping. Generally, participants were able to recall examples of both adaptive and maladaptive forms of coping, including adaptive and maladaptive forms of religious coping. Many of the participants named maladaptive forms of coping. In particular, participants noted over-use of medication and relying solely on the spiritual as maladaptive forms of coping. For example, Participant 6 stated, "Yeah, but one thing I see, and I would say this. Now in society everything is medication. Everything is really medication." Participant 8 spoke about maladaptive forms of coping stating, "I don't believe shouting over it will fix it all the time, but I hear it all the time."

It seems that some of the participants noted that overuse of spiritual practices, like shouting, often were signs of maladaptive coping.

Research Question 6

The purpose of research question 6 was to investigate how participants thought about how anxiety and depression develop. Typically, participants thought anxiety and depression originated from spiritual and social factors. Participant 1 stated:

> Relationships. Big. Big. The kind of things they encounter in their life. And this again is where salvation comes in. You cannot – it's about like a noun, person, place or thing. You cannot let people be your source. And you cannot let a thing be your source. All this stuff is a resource. You're going to have to make God your source.

Variant responses included complex sources, personal choices, and biological considerations. In fact, only one participant mentioned biological factors separate from the other spheres of influence. When other participants spoke about biological factors, they were coupled with other spheres of influence. For example, Participant 2 stated

> I mean they are, you have some hereditary factors as well too. But biological factors they exist. I mean they, they do. Do I totally believe 100%? I mean I believe they exist but again there are choices that are involved in us making necessary things to keep it from affecting us the way it does sometimes.

In sum, then, it appears that pastors in this study placed emphasis on spiritual and social factors as the primary precipitants of anxiety and depression. This is not entirely surprising as these are the domains (spiritual and social) in which organized religion have their greatest influence.

Discussion of Domains and Categories

Six research questions provided the structure for this empirical study. From the data analysis process, the research team identified six domains. The domains include: (a) frequency/type of mental health issues, (b) perspectives on mental health services, (c) causes of mental health issues, (d) coping with mental health issues, (e) on being a pastor, and (f) African American experience. In addition, seven categories emerged as *general,* ten categories emerged as *typical*, and eight categories emerged as *variant.* In this investigation, categories were labeled *general* if present in 7-8 of the cases, *typical* if present in 4-6 of the cases, and *variant* if present in 1-3 of participant cases. In the following section, the author will discuss each domain in more detail. In this discussion the author will integrate findings from this study coupled with knowledge from existing literature.

Frequency/Type of Mental Health Issues

Findings from this study confirm existing literature that many African Americans frequently seek help from their pastors on various mental health issues (Veroff et al., 1981). Many participants shared that congregation members approached them on a daily basis. Previously, researchers had suggested that parishioners often sought pastoral guidance on issues such as relationships, substance abuse, unemployment, grief, depression, physical health, and other emotional issues (Neighbors et al., 1998). Carter et al. (1996) suggested that prevalence data for the number of African Americans experiencing anxiety is conflicting with no clear sense of actual prevalence. Results from this study, however, support the notion that anxiety and depression are common among

African Americans in religious communities. Further, pastors did not differentiate between clinical and sub-clinical levels of anxiety and depression. In fact, the participants implied that much of the anxiety and depression that they see in congregation members is undiagnosed. Additionally, a few of the pastors alluded to experiences with congregation members experiencing forms of complicated grief (American Psychiatric Association, 2000; Burke et al., 2011). Typically, when pastors encountered members who were experiencing more complicated forms of grief, they suggested referring them to professional counselors.

It seems that even when African American pastors face challenges, such as limited resources, they are expected to respond to various needs in their congregations (S. K. Roberts, 2003). The participants seemed to identify responding to congregants' distresses as one of their most significant time commitments and responsibilities. The current literature has cited many reasons why African Americans are less likely to seek help from formal sources such as professional counselors and more likely to seek help from informal sources such as extended family and spiritual leaders (Ayalon & Young, 2005; Woodward, 2011). Some of these reasons have included attitudinal barriers such as stigma and cultural mistrust and structural barriers such as access to care and insurance coverage to seeking help from formal resources. Results from this study support existing literature that includes stigma as an attitudinal barrier. Additionally, results from this study seem to suggest that the history of African Americans also is considered an attitudinal barrier to seeking help outside of the church. Moreover, researchers have suggested that attitudinal barriers seem to supersede structural barriers (Alvidrez et al.,

2008; Takeuchi et al., 1988; U.S. Department of Health and Human Services, 2001) and results from this study seem to support this notion as participants devoted more time discussing how stigma and history impacted help-seeking compared to other issues such as insurance and monetary resources.

Participants also shared that parishioners seek guidance in both formal and informal methods. Participants cited informal methods of contact with congregants such as texts and phone calls. Based on results from this study, it seems that the accessibility of pastors could also be a reason why African Americans are more likely to consult them in times of distress. For example, parishioners may be able to contact pastors at any time, whereas professional counselors would likely not be able to provide this level of availability. It is also likely that advancements in technology (i.e. texting, social media) have increased the accessibility of pastors.

On Being a Pastor

Billingsley (1999) noted that just as individual congregations can be distinct, so could be the characteristics of its leaders. However, researchers and scholars have documented the influence, power, and many roles and responsibilities that accompany being a senior pastor in the Black Church. Researchers and scholars have noted that African American pastors are charged with caring for their congregation in secular and spiritual ways, which could include providing a familial structure for parishioners with pastors serving as parental figures, serving as a counselor for various mental health issues, engaging in community activism, and influencing social and political change (Billingsley, 1999; Bitner, 1984, C. E. Lincoln, 1973; Singleton & Roseman, 2004;

Wimberly, 1991; J. L. Young et al., 2003). Specifically, Welch (2011) suggested that African American pastors, in particular, have the unique responsibility to respond to the social injustices in the African American community. The current study both confirms information in the scholarly literature and contributes needed information to the scarce body of empirical literature regarding pastoral roles in providing mental health services. Generally, participants spoke about how they provide support within the congregation and how they direct congregants to resources inside and outside of the church.

Complex roles. Although the existing literature has focused on the many roles that African American pastors are expected to fulfill (Billingsley, 1999; Bitner, 1984, Singleton & Roseman, 2004; Wimberly, 1991; J. L. Young et al., 2003), participants in this study did not seem to focus as much on their multiple roles, though this may be partially an artifact of the specific questions that were asked of them. A few participants indicated situations in which they were expected to act outside of the church in roles other than pastor and counselor. One participant recalled an incident where he was asked to serve as an advocate for a church member in the judicial system. Two participants spoke about being surrogate father for youth in the congregation. Interestingly, these two were the only participants who did not have children themselves. It is unclear from this study whether other participants are not fulfilling additional roles in the lives of congregation members, whether these roles are just assumed to be a part of the responsibility and thus are not specifically articulated by pastors, or whether the specific interview questions used in this study did not access this information.

Black Church. A few of the participants specified pastoring in the Black Church as a unique experience. Only one participant noted the power and influence that accompanies pastoring in the Black Church. The participant who noted the historical development and influential power of African American pastors was the participant with the doctoral degree, the highest education level of all the participants. It is unclear from the results of this study whether other participants were less aware of the historical significance of the Black Church and concomitant implications for pastoral power, whether they intentionally chose not to mention this, or whether the interview questions did not explicitly tap this information.

Resources. In the current study, the majority of pastors indicated counseling as an appropriate resource for congregation members experiencing distress; however, many participants specified *Christian* counseling as an acceptable form of mental health services. Researchers have noted that Blacks are less likely to seek help (Avalon & Young, 2005) and that this could be because secular clinicians are not as sensitive to the spiritual and religious influences in the client's lives. Results of this study suggest that pastors may be referring congregation members to counselors but only to counselors that they know are also Christians. Results from this study inform the literature with more information regarding African American help seeking. African Americans are consistently underrepresented in secular counseling help-seeking populations (Avalon & Young, 2005), but results from this study suggest that this could be due to the fact that they are likely to be referred by pastors specifically to Christian counselors. Researchers have focused on cultural mistrust in terms of racial and ethnic demographics. Results

from this study suggest, however, that cultural mistrust may also be applicable in terms of religious affiliation. Participants indicated that they felt safe sending parishioners to Christian counselors not necessarily because they were more competent or qualified but because they would attend to the spiritual needs of their congregants. Researchers such as Townes et al. (2009) have suggested that African Americans prefer a Black counselor. Results from this study suggest, however, that a primary consideration in referrals is the religious affiliation of the counselor, ostensibly because the assumption is made that a Christian counselor will be more respectful of the client's religious and spiritual beliefs. What could prove increasingly difficult is when African Americans are searching for counselors who match them both in racial and religious demographics.

Within the general population, Broman (2012) found that African Americans who are more educated are also more likely to engage in help seeking for mental health issues outside of the church. The findings for pastors was not consistent with this as there did not appear to be differences in openness to referrals to mental health professionals based on the education level of the respondent. In the current study, in fact, all participants, regardless of education, acknowledged their limitations in providing support and care for members with varying stressors and thus appeared open to referring members to seek help outside of the church. What remains unclear are the exact procedures and protocols that pastors may follow when they make referrals.

Development. One of the themes that emerged unexpectedly from the data was the pastor citing parishioners' growth and development as one of their greatest rewards in pastoring. Results from this study suggest that people often present in emotional turmoil

and through ministry are transformed into a place of wellness. All of the participants seemed to value this transformation. It may be that the emphasis placed on development by participants influence both the investment they make in their development and the willingness and openness to seek resources outside the church when needed.

Perspectives on Mental Health Services

Connor et al. (2009) suggested that African Americans, in general, felt more negatively towards mental health treatment, but results from this study indicate that participants had a generally favorable view of the counseling profession. Overwhelmingly, participants were able to recall more positive rather than negative experiences with mental health care providers in their communities; therefore, results from this study suggest that pastors have more positive than negative experiences with mental health care providers. This finding must be considered, however, in the context of the finding that participants tended to prefer making referrals to counselors that they knew were Christians themselves. It is unknown to what extent the choice of counselor religiosity was formed by negative experiences with secular counselors.

Although negative experiences with the mental health service delivery system were not pervasive among this sample, results from this study indicate that they assuredly do still exist. For example, participants noted a lack of empathy from practitioners as one of the more common negative experiences. It is possible that this lack of empathy could stem from insensitivity to spiritual and religious considerations as well as cultural competency, hence the emphasis by some of the participants on Christian counseling. Interestingly, the participants who noted negative experiences with mental health care

providers were among the younger participants. Researchers have noted the effect that pastoral characteristics such as age and education level may have on their involvement in the community. For example, Billingsley (1999) found that younger pastors with more education tend to be more engaged with their local communities and use resources external to the church with more frequency. It is possible, though not confirmed in this study, that an increased use of external resources by younger pastors explains, at least in part, the increase in negative experiences.

Causes of Mental Health Issues

The existing literature lists cultural mistrust, racism, and hyperawareness of physical illnesses as potential contributors to anxiety in African Americans (Hunter & Schmidt, 2010). Results from the current investigation add to the current body of literature. Specifically, participants typically attributed anxiety and depression to spiritual and social factors. Existing literature, although scarce, has supported the notion that African American pastors are more likely to endorse spiritual causes of mental health issues such as depression (Payne, 2009). Participants in the current investigation cited lack of faith, spiritual warfare, neglecting the spiritual, unanswered prayers, and demonic influences as possible causes of anxiety and depression. The lack of faith in God seems to parallel themes found in previous research (Payne, 2009). Of importance, however, Payne (2009) focused exclusively on investigating pastoral beliefs regarding the etiology of depression, while the current study investigated other mental health issues as well. Results from Payne (2009) and the current study do seem to confirm, however, that pastors tend to emphasize spiritual influences on mental health issues. Results from this

study also corroborate previous findings on the influence of social factors. For example, Hunn and Craig (2009) mentioned stress as a contributing factor to depression in African American women. In this study, pastors reported that a significant amount of stress stems from relationships and societal contexts. Results from this study suggest that African Americans exert a lot of energy in trying to maintain lifestyles consistent with what they see in other people. For example, many of the participants noted parishioners' fixations of paralleling others' material wealth. Participants seemed to suggest that there was a societal standard of wealth that many African Americans struggle to meet and that anxiety and depression result from this.

There were a few participants who identified etiology as complex, specifically indicating that anxiety and depression could be attributed to a combination of influences. Participant 5 was the lone pastor to specifically identify biological factors as a solitary influence on mental health issues. That is, other participants identified biological factors in conjunction with other factors (coded as complex influences). Similarly, Payne (2009) found that African Americans were less likely to view depression as a "biological mood disorder". Interestingly, the participant who suggested that biological factors might be the sole factor in mental health issues in some cases was also the participant with the most advanced educational degree. Although this finding is not generalizable, it is noteworthy and may need to be considered in subsequent studies.

Coping with Mental Health Issues

Existing literature regarding how African Americans pastors view coping within their congregation and how they influence members' coping styles is scarce. Results from

this investigation provide new information in this regard. Specifically, results from this study suggest that African American pastors endorse complex coping strategies as the most favorable coping strategies. Although complex was a variant category in *Causes of Mental Health Issues,* it was a general category in the *Coping with Mental Health* domain. In other words, pastors were more likely to endorse complex, integrative treatment approaches (coping) than integrative beliefs regarding the etiology (causes) of anxiety and depression. One of the themes that emerged within the complex category was the limitations of spiritual coping. Burke et al. (2011) acknowledged spiritual coping as an asset in coping with bereavement, but also stated that while spiritual coping is important, it is not always sufficient. Results from this study support the existing literature as participants noted the limitations of spiritual coping and, accordingly, endorsed incorporating other strategies such as counseling and medication.

Typically, pastors also noted social coping as an appropriate form of coping. Wiley et al. (2002) challenged researchers to investigate African American social support systems because much of the existing literature focuses on deficits in African American social networks. Results from this study suggest that pastors identify social relationships as a significant adaptive source of coping. Results from this study also suggest that African American pastors themselves serve as integral sources of social support for many African Americans during times of suffering. For example, some participants indicated that they served as surrogate fathers for members of the congregation from single parent homes and seem to be heavily involved in parishioners' relationship and parenting matters. Further, Collins and Doolittle (2006) suggested social support as an integral part

of the bereavement process. Results from this study contribute more information about how pastors provide social support during this time for many families as well as the focus on social support from other parishioners in the church. Participants noted experiences that ranged from helping families make decisions about ending life support to helping families plan the funeral services. It is less clear, however, what services are provided to surviving family members.

Results from this study also provide insight concerning African American spiritual coping. Consistent with current findings, results from this study suggest that spiritual coping seems to be a popular form of coping for people struggling with various mental health issues (Tepper, Rogers, Coleman, & Maloney, 2001). In fact, Pargament (1997) suggested that members of "less powerful groups" (p. 156) often engage in religious coping more often than other more powerful populations. These findings support quantitative findings that suggest that religious coping is effective in decreasing symptomatology experienced with depression and anxiety (Tepper et al., 2001). Participants noted correct interpretation of scripture, demonstrated faith, and commitment to spiritual practices (i.e. prayer) as means to adaptive and beneficial spiritual coping. These practices seem to be consistent with Pargament's (1997) concept of *collaborative coping*, in which the person involves God in the healing process, but recognizes a personal responsibility to be an active part of the process as well. It also seems that African Americans utilize seeking spiritual support from clergy or church members. While results from this study suggest this as a frequent religious coping style, no data was

collected on effectiveness of this approach as this research focused on pastoral perspectives rather than congregants' reports.

Results from this study indicate that African American pastors value spiritual coping as an adaptive and effective approach, but also emphasized that it must be executed properly as participants seemed to differentiate between adaptive and maladaptive forms of religious coping. Results from this study suggest that pastors do not endorse maladaptive forms of spiritual coping. Although participants did not specifically identify *spiritual bypass* as an avoidant, maladaptive form of coping, their descriptions seem to match portrayals of *spiritual bypass* in the current literature. Welwood (2000) defined spiritual bypass as a means of distraction from psychological pain by immersing oneself in spiritual practices. Scholars have identified manifestations of spiritual bypass that include spiritual narcissism, spiritual addiction, spiritual materialism, blindly following a leaders, and abandoning personal responsibility (Booth, 1991, Cashwell et al., 2004, 2010; Ellis, 2000; Rosenthal, 1987; Welwood, 1984, 2000; West, 2000). Currently, there is a scarce amount of empirical literature about spiritual bypass because of the difficulty in assessment. Results from the current inquiry suggest that an over-reliance on public forms of spiritual coping (i.e. shouting) while neglecting emotional distress is often seen as maladaptive forms of coping. Interestingly, public forms of expressiveness in worship, such as shouting, are distinguishing characteristics of the Black Church (C. E. Lincoln, 1973). Other forms of maladaptive coping mentioned by participants include *demonic appraisal* (i.e. blaming the devil) and *spiritual discontent* (i.e. unanswered prayers (Pargament, 1997).

Typically, participants identified avoidance as a coping strategy that they saw in congregation members. Results from this study suggest that pastors do not encourage avoidance coping strategies and in fact, suggested that this approach could heighten struggles related to anxiety and depression. Participants seem to suggest that avoidance is a maladaptive coping strategy that serves as a barrier to help seeking among African Americans, in particular. This is consistent with the work of Andrews et al. (2010), who found denial as one of the barriers to African American help seeking. Results from this study suggest that this denial could be due to a lack of information or, in some instances misinformation. Participants seemed to suggest that they perceive avoidance as being particularly common and problematic in the Black Church.

Interestingly, participants also indicated over-reliance on medication as a form of maladaptive coping. Cooper et al. (2012) reported that African Americans tend to dislike medication as a form of coping, are more likely to see medication as addictive, and are less likely to endorse medication as effective. It seems that these attitudes serve as a deterrent to help-seeking behaviors (Cooper et al., 2012). Results from this study seem to support this notion as participants recalled accounts of over-medication or misappropriation of medication and the subsequent negative side effects, such as altering personality.

Generally, participants also noted that as pastors they experienced anxiety and depression as well. Only one participant stated that he had never experienced any anxiety or depression in his entire life, citing biblical principles as his primary coping strategy. Results from this study suggest that pastors have taxing responsibilities and are at-risk for

burn out, similar to other helping professionals. Participants emphasized spiritual coping and social coping strategies for themselves, which could explain their emphasis on spiritual and social coping for their congregation members. Moreover, some participants seemed to put restrictions on how they allowed themselves to experience anxiety and depression. For instance, some participants acknowledged that they had been anxious or depressed but felt that they could not stay in this state for an extended amount of time. Given these statements from participants, what is unclear from the data is the extent to which these participants work through their anxiety or depression versus the extent to which they, themselves, engage in some form of avoidant coping.

African American Experience

Results from this study indicate that there is something unique about the relationship between African Americans and mental health help seeking behaviors. Typically, participants seemed to emphasize attitudinal barriers to treatment, such as history and stigma, as opposed to more structural barriers, such as insurance and access to treatment. This is consistent with existing literature in which researchers have found attitudinal barriers more prevalent than structural barriers to treatment among African Americans (Alvidrez et al., 2008; Takeuchi et al., 1998; U.S. Department of Health and Human Services, 2001). Results from this study suggest that pastors recognize stigma in their congregations but are challenged in trying to contest stereotypes and preconceived notions concerning seeking help for mental health issues. Findings from this current investigation suggest that stigma could be attributed to a combination of historical considerations and religious expectations. Other researchers have identified resilience as

a deterrent to seeking help from formal resources (Chandler, 2010; Krause, 2009; V. L. S. Thompson et al., 2004). Findings from this current investigation suggest that history could also be a barrier in African American help-seeking. While the implications of history emerged throughout the data, participants spoke about in a variety of ways. For example, some participants noted that African Americans tend to value tradition and have a difficult time with change, another participant noted African Americans' history of being accustomed to suffering and subsequent development of resilience and endurance, and another participant noted African Americans' lack of knowledge about mental health care as historical barriers to seeking help outside of the church. However, what remains less clear from the current study are the specific historical catalysts for these attitudinal beliefs as participants did not name specific historical events that may have contributed to this attitude among African Americans.

Limitations

Reporting the details of human experience is difficult. Accordingly, no study is void of limitations and exempt from critique (Freeman et al., 2007). As suggested by Knox, Schlosser, and Hill (2012), the researcher reflected on the research protocol, participants, qualitative philosophy, participant sample, and other nuances of the study and wanted to inform the readers, with as much transparency as possible, about the limitations of the study. Although limitations can evoke feelings of researcher vulnerability, they need to be addressed so that they also can empower readers as they read the final write-up and begin to draw their own conclusions about the results (Sim et al., 2012).

One of the limitations of this research study involved the participant sample. Because of the qualitative research design, the sample was relatively small (n = 8) and, accordingly, results should be interpreted with caution. Further, participants were recruited via a non-random, purposive sampling method. The demographics of the sample could also be considered a limitation. In particular, the participant sample was majority male, with only one participant identifying as female. It is unclear as to how this may have specifically impacted the results. It might be beneficial to have a more diverse sample in future research studies, though the majority of senior pastors in the Black Church are male. Additionally, it is important to note that all participants live in the same state in the southeastern region of the United States. The restrictive geographic region could limit the representativeness of this sample to the population of interest. Given the sensitivity of the subject matter, participants could have provided socially desirable answers for purposes of this interview. Further, because of the variation of church membership and staff positions in the church, the participants could have varying levels of interaction with their respective congregations, possibly impacting the results. In particular, one church was an outlier in terms of congregation size and the number of staff, being much larger than the other churches represented in the study. It is unknown how this may have affected the responses of the pastor of this church.

Also, it is important to note the limitations that stem from the research team as each member had his or her own biases, expectations, and experiences that could influence the interpretation of data (Knox et al., 2012). Although the research team made efforts throughout the data collection and analysis process to minimize the effect of

research team biases and expectations it is still possible, due to the nature of qualitative procedures, that the data were affected. All of the research team members were academically affiliated with the same university, which could have somehow influenced their analysis of the data. Further, two of the research team members and the auditor were African American females and one member was a Caucasian male. All the members of the research team had similar religious backgrounds in that they all had some personal affiliation with the Baptist Church at some point in their lives. Although bracketing and triangulation strategies were used to minimize bias, it remains possible that some researcher bias entered into the process.

Implications for Counselors and Counselor Educators

The findings from this study provide useful information for counselors and counselor educators. Generally, participants seemed to have favorable opinions of counseling and saw a need for professional services for congregation members. Counselors have an opportunity to form collaborations with local pastors in their community. Pastors seemed to be selective when referring congregation members outside of the church, and thus counselors should be mindful of the importance of building relationships with pastors in order to form trust. Moreover, Himle et al. (2009) suggested that more data regarding prevalence of mental health issues, specifically anxiety, could inform strategies for education, outreach programming, and treatment plans. Results from this study support the notion that mental health issues are prevalent in the African American community and that counselor educators and counselors have ample

opportunities to conduct programming in the community, potentially using local Black churches as hosts for these programs.

The current study suggests that pastors identify Christian counselors as competent and trustworthy in providing services to their parishioners. This finding has implications for counselor educators and counselors. Cashwell and Watts (2010) and Pulchaski and Romer (2000) challenged practitioners to be more inclusive and attentive of client's spiritual backgrounds and cognizant of how these considerations could be influencing their presenting concerns. It is important that counselor educators and counseling practitioners are aware of nuances in African American religion and spirituality and messages they could be receiving about etiology and coping from their spiritual leaders. Counselor educators have an opportunity to be more intentional when teaching counselors-in-training about incorporating client's spirituality in counseling session. One vehicle for integrating spirituality within the counseling curriculum is to teach the spirituality competencies developed by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC; Cashwell & Watts, 2010). This seems to highlight the impetus of respectfully integrating client spirituality into counseling (Cashwell & Young, 2011). Further, it seemed important to participants that counselors acknowledge the client's faith as a significant part of the treatment recommendation. Moreover, pastors seemed to value an integration of the biological, psychological, social, and spiritual when treating various mental health issues. Accordingly, it seems important for counselors to remember this when forming treatment plans and recommendations. Finally, the significant role of pastors in the lives of parishioners within the Black Church

must be remembered. Any statement or act from a counselor that is perceived by the client as demeaning the pastor likely will hurt, if not destroy, the therapeutic alliance that is starting to form.

Participants also noted over-medication as one of the flaws of the mental health care system. It is important for practitioners to consider client's beliefs regarding medication and how it may affect their personalities and presentation. There is also an opportunity for counselor educators and counselors to provide psychoeducation to clients and community pastors on diagnosis and various types of medication that could be prescribed.

Participants also spoke about their own struggles with anxiety and depression. It seemed that pastors found it difficult but necessary to incorporate forms of self-care in their routines. Counselor educators and practitioners have the opportunity to provide pastors with education regarding coping skills and the importance of self-care to help minimize feelings of burnout.

Suggestions for Future Research

Previous literature on pastoral influence on mental health help-seeking is scarce and, therefore, this qualitative study provided important preliminary information on pastoral roles in the mental health lives of their congregation members. Because of the paucity of existing research, this qualitative research was considered appropriate to inform the existing literature. In the future, however, it seems important to include mixed-methods or quantitative research methodologies. Given the aforementioned limitations of the current study, more research is needed to continue to develop this line

of knowledge. In future research, larger and more diverse samples are needed to replicate the findings from this study. Although there are important preliminary results from this study, it is important to continue to assess the external validity of these findings and to systematically examine variance among diverse pastors. In particular, more female senior pastors need to be included in future participant samples to gain more information about their perspectives on mental health and coping. Because there was only one female pastor in this study, it is unclear how this impacted the findings and how, if at all, women who pastor churches differ from their male counterparts.

Although not the focus of this research study, it would likely benefit this body of literature to explore the influence of church theology on pastor's approaches to help-seeking behaviors. For example, researchers could create a survey that assessed for pastors' beliefs about help seeking particularly for mental health issues. Additionally, participants could complete questionnaires that assess their theological beliefs and then these could be compared with beliefs regarding help-seeking behaviors. Other factors, such as age and education level of the pastor, also could be examined.

Additionally, future researchers could further investigate avoidant coping. Participants spoke about avoidance as a coping strategy used by many congregation members. Specifically, participants recalled parishioners who used their religion as a means of avoidance. This concept is referred to as *spiritual bypass* in the literature. Future researchers could create a measurement of *spiritual bypass* to give to clients to help guide treatment recommendations and provide more clarity in case conceptualizations. Currently, it is difficult to assess for *spiritual bypass* because people

usually score high on other spirituality measurements because they are often actively engaging in spiritual practices.

Further, the current study emphasized the influence of history on coping strategies. Future researchers could conduct a qualitative study that would investigate this in more detail, aiming to get additional information about the specifics of how African American history has influenced current help-seeking behaviors. While it seems that this study has confirmed existing literature about stigma being a barrier to help seeking, it still remains unclear as to how stigma has evolved over time and how it continues to be a part of the African American experience. Awosan et al. (2011) called for a reinvention of African American culture in order to reduce stigma. Future researchers could survey African Americans regarding the role that stigma currently plays in their lives and the messages that they currently receive and internalize about seeking help for mental health concerns. Participants in this study did not specify their role in perpetuating stigma, so future researchers would be well served to examine this issue.

One clear limitation to the current study is that all of the information is based on self-report which, in theory, may not perfectly coincide with practices in the church. In particular, it is possible that participants may have given socially desirable answers. Future researchers could use content analysis to analyze beliefs disseminated by preachers during sermons. Watson et al. (2003) noted the significance of the pulpit and the ways in which it can be used to disseminate pastors' personal beliefs and opinions. In the future, researchers could compare ideas disseminated in the pulpit or during worship services to information gathered when talking with pastors one-on-one.

The current investigation focuses on the perspectives of the pastors. Future research also could investigate parishioners' perspectives and compare the different accounts. For example, future qualitative researchers could interview parishioners who have sought help from their pastors and ask them to give detailed accounts of the guidance they received from their pastors as well as messages they received about etiology and coping with various mental health concerns.

Because of some of the themes that emerged in the current study, it might extend the current body of literature to have more information regarding practitioner perspectives of providing care for religious African American clients. There are several possibilities for researchers to garner more information in this area. For example, researchers could create a survey to measure practitioner knowledge of the Black Church and their thoughts regarding providing services to the African American religious community. Further, researchers could create a survey that measured counselor sensitivity to religious and spiritual considerations, particularly with African American clients. Alternatively, researchers could examine audio/video or transcripts of counseling sessions with religious African American clients to examine the level of empathy and respect that is shown toward the religiosity of the client.

Only two of the participants mentioned suicide in their responses. One participant spoke of it as something that is foreign to the culture of African Americans, while another participant spoke about it as something that needs to be addressed, particularly within his own community. The literature could benefit from more investigations on pastors' experience with suicide in their congregation, their beliefs regarding suicidal ideation,

responses to members who disclosed suicidal ideation, and issues of aftercare when suicide occurs.

Participants seemed to acknowledge both informal and formal ways of contact with African Americans when they are in distress. Researchers could focus on the influence of technological advances (i.e. social networking) on African American help seeking behaviors. It seems that pastors' availability and accessibility may be a contemporary factor in African Americans seeking help from them rather than other sources that may have more difficulties with access (Alvidrez et al., 2008). With the advancement of technology and popularity of texting and social media sites such as Facebook and Twitter, it is likely that this accessibility has increased and future research could inform this body of literature on how this has impacted African American help seeking behaviors, specifically with their pastors.

Additionally, pastors seemed most open to referring to counselors if they knew that the counselor was a Christian. Thus, the existing body of literature could benefit from future studies investigating more about this link and what pastors expect from a Christian counselor that they might not expect a secular counselor can provide. Researchers could investigate how familiar secular counselors are with theology and characteristics of the Black Church and their level of competence in working with religious African-American clients. Results from such a study could further inform why pastors are more willing to refer to Christian counselors. Further, future research could focus on the interface between cultural competence with racial/ethnic minorities and cultural competence with religion and spirituality.

Cabrel and Smith (2011) suggested that African Americans have superior treatment outcomes when paired with a Black counselor. It is possible, though, that in some cases negative outcomes with a White counselor may stem not from cultural incompetence related to issues of race and ethnicity, but rather to cultural incompetence surrounding the salience of religion and, in particular, the religious experience in the African American community. Future researchers could compare treatment outcomes of African American clients paired with an African American counselor and African American clients paired with a Christian counselor. Results from that study could inform whether it is more important that African Americans are matched with counselors of the same race, the same religious affiliation, or whether it is competence in working with issues related to race and religiosity that are most salient. In addition, researchers could conduct a phenomenological study with Christian counselors to discover more about their practices and how they may be similar and/or different than secular counselors. Because Diala et al. (2000) indicated that there was something significant about the first session for African Americans that influenced their decision to continue treatment; it may be helpful to investigate in detail the first sessions of Christian counselors and how they may compare to first sessions of traditionally secular counselors.

Conclusion

As mental health professionals, counselors seek to provide effective services to people from various backgrounds and life experiences. The current study provides more information about pastors' perceptions of mental health service providers, beliefs about causes of mental health, and attitudes regarding appropriate and inappropriate forms of

coping. This study increases current knowledge about religious African American clients and provides future researchers with numerous possibilities to further investigate the subject matter.

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APPENDIX A

PARTICIPANT CONSENT FORM

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO
CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORM

Project Title: *"What Then Shall We Say to These Things? An Investigation of Pastoral Response to Mental Health Needs in the Black Church".*

Project Director: Dr. Craig S. Cashwell

Participant's Name: _____

What is the study about?
This is a research project. The purpose of this study will be to investigate pastors' responses to parishioners dealing with anxiety and depression and the level and type of support offered.

Why are you asking me?
You have been asked to participate in this study because you are over 18 years of age and a senior pastor of an African American church. Because of this, you have expert knowledge of the subject matter.

What will you ask me to do if I agree to be in the study?
If you choose to participate in this study, you will be asked questions concerning your experiences being a pastor and attending to the mental health needs of members of your congregation. You will be asked to commit approximately 90 minutes of your time, which includes reviewing the informed consent, completing the demographic questionnaire, answering questions of the interview, and reviewing the typed transcripts for accuracy.

If you agree to participate in this study, the student researcher will email you a copy of the informed consent, which will include information about the topics to be discussed during the interview at least five days prior to the scheduled interview. After completing the interview, the student researcher will email or mail you a copy of a written transcript of your answers for you to review for accuracy. You will be asked your preference for receiving the written transcript. If you have any questions you can contact the student researcher at jravent@uncg.edu,

Is there any audio/video recording?

The interviews will be audio-recorded. Audio recordings will be treated as confidential information solely and used to transcribe the interviews into a written (typed) format. Only the three members of the research team (Janee'Avent, Shelly Brown-Jeffy, and Craig Cashwell) will review the audio recordings. Any identifying information (such as your name, the name of your Church, or the name of a parishioner) in the interview will be redacted from the written transcripts. The research team will then use the written transcripts as data in the analysis process.

What are the dangers to me?
The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants.

If you have any concerns about your rights, how you are being treated or if you have questions, want more information or have suggestions, please contact Eric Allen in the Office of Research Compliance at UNCG toll-free at (855)-251-2351.

Questions, concerns or complaints about this project or benefits or risks associated with being in this study can be answered Dr. Craig S. Cashwell who may be contacted at cscashwe@uncg.edu or (336) 334-3427. In addition, the student investigator, Janeé R. Avent can be reached at jravent@uncg.edu and by phone at (252) 885-8936.
Are there any benefits to society as a result of me taking part in this research?
Understanding the services provided by pastors of the Black Church it may lead to better understanding the mental health services received by many African Americans. Counselor educators may also increase knowledge and be able to better train counselors in training in providing services to African American clients.

Are there any benefits to *me* for taking part in this research study?
You may benefit from expressing your views on this issue as this could lead to an increased awareness about your role as a pastor in attending to the mental health needs of your congregation members.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments made for participating in this study.

How will you keep my information confidential?
All information obtained in this study is strictly confidential unless disclosure is required by law. Any identifying information will be stored in a password protected document on a password protected computer that is only accessible by the lead student investigator. Access to audio recordings will be limited to the three researchers identified above and any identifying information will be redacted from the written transcripts.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state.

What about new information/changes in the study?
If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:
By signing this consent form you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By signing this form, you are agreeing that you are 18 years of age or older and are agreeing to participate, or have the individual specified above as a participant participate, in this study described to you by Janee' Avent.

Signature: _____ Date: _____

APPENDIX B

PARTICIPANT RECRUITMENT LETTER

Janeé R. Avent
The University of North Carolina at Greensboro
Department of Counseling and Educational Development
228 Curry Building, PO Box 26170
Greensboro, NC 27402
Email: jravent@uncg.edu

Pastor _____
Address
Address

Dear Pastor _____,

As a pastor I imagine you assume many roles in the lives of your congregation member as people depend on you for a number of services. Through both my scholastic research and personal experience, I have seen how vital you are in the lives of people as they both celebrate and struggle. My name is Janee' Avent and I am a doctoral student at The University of North Carolina at Greensboro conducting research to complete my dissertation entitled *"What Then Shall We Say to These Things? An Investigation of Pastoral Response to Mental Health Needs in the Black Church"*. I am interested in learning more about your role in responding to members of your congregation who are struggling with mental health issues.

Because you are the senior pastor of a predominately African American congregation, you qualify to participate. If you choose to participate in the study you will be asked to participate in an interview that will last approximately 90 minutes. The interview will include questions about your response to various presenting concerns of your members, the etiology of some of these concerns, and your experiences with the mental health community. It is important to note that the interviews will be audiotaped; however all your information will be kept anonymous. In fact, in lieu of using your name in the final narrative you will be assigned a participant number for identification purposes.

If you are interested in participating please contact Janee' R. Avent by email at jravent@uncg.edu or by telephone at (252) 885-8936 to receive the additional documents and instructions for participation. You may also contact my dissertation chair, Dr. Craig

S. Cashwell at cscashwe@uncg.edu or (336)334-3427 Should you have any additional questions or need more information please do not hesitate to ask.

With sincere gratitude,

Janeé R. Avent

Janeé R. Avent, MS, LPCA, NCC
Doctoral Student
Department of Counseling and Educational Development
The University of North Carolina at Greensboro

APPENDIX C

PARTICIPANT FOLLOW UP LETTER

Janeé R. Avent
The University of North Carolina at Greensboro
Department of Counseling and Educational Development
228 Curry Building, PO Box 26170
Greensboro, NC 27402
Email: jravent@uncg.edu

Pastor _____
Address
Address

Dear Pastor _____,

I am so pleased that you have agreed to participate in my research study, *"What Then Shall We Say to These Things? An Investigation of Pastoral Response to Mental Health Needs in the Black Church"*. Please contact me with your availability so that we can schedule a time to meet for the interview.

As you prepare for the interview please be reminded that we will be discussing how you as the senior pastor of your church respond when members seek your guidance on various concerns that may be affecting their overall mental health and well-being. As a part of the interview you will be asked to complete a demographic questionnaire that will ask for some basic information.

As always, should you have additional questions or need more information please feel free to contact me at jravent@uncg.edu or by telephone at (252) 885-8936. I am looking forward to meeting with you.

With sincere gratitude,

Janeé R. Avent, MS, LPCA, NCC
Doctoral Student
Department of Counseling and Educational Development
The University of North Carolina at Greensboro

APPENDIX D

PILOT STUDY DEMOGRAPHIC QUESTIONAIRE

Age: _____

Gender: _____

Denomination: _____

Church Size: _____

Geographic Region: _____

No. of Years as Pastor: _____

Education Level: _____

Degree: _____

APPENDIX E

FULL STUDY DEMOGRAPHIC QUESTIONAIRE

Age: _____

Gender: _____

Relationship status: _____

Denomination of church you pastor: _____

Number of church members: _____

City in which church is located: _____

No. of years as Pastor: _____

Highest Level of Education Completed (Please choose from one of the following):

☐ high school diploma ☐ some college ☐ associate degree

☐bachelor's degree ☐ master's degree ☐ doctorate degree

Degree: _____

From where did you receive your highest level of education: _____

In what year did you receive your highest educational degree: _____

Please provide some information about the other staff positions in your church

_____

_____

_____

If available, please provide a copy of your church organizational chart.

APPENDIX F

ORIGINAL INTERVIEW QUESTIONS

1. I want to begin by learning a little bit more about you and your ministry. Tell me about your background pastoring in the Black Church.
    a. How and when did you receive your call into the ministry?
    b. What do you find most rewarding in work as a pastor?
2. Tell me about your training as a pastor/counselor?
3. How would you describe your church?
    a. According to scholars there are two primary different types of churches "this worldly" and "other worldly." Typically, "this worldly" churches have a present focus, working to achieve happiness in this present life and "other worldly" tend to be more focused on the afterlife and the promises of reward in heaven. How would you describe your church using this language?
4. I'm going to transition now and ask some more specific questions about your role providing support to congregation members. How do you respond to a member who seeks your guidance following a traumatic life event or stressor (i.e. bereavement or relationship difficulty)?
5. Have you or someone close to you ever struggled with anxiety or depression? Please be as specific as possible, sharing as much information as you feel comfortable.

6. How do you see your role in attending to the mental health needs of members of your congregation? For example, how would you describe your role if a member approached you and stated that they were struggle with anxiety and/or depression?
7. Describe your process in determining what services a congregation member may need when they express to you that they are struggle with anxiety and/or depression.
8. I want to ask you about how you think about anxiety and depression. There is a model that says issues like depression and anxiety are a combination of biological, psychological, social, and spiritual factors. What percentage of anxiety and depression do you attribute to biology, psychology, social, and spiritual factors ?
    a. Let's look at each of these factors separately. Do you think it is possible to over (or under) use any of these as coping methods?
9. What are some of your positive and negative experiences with mental health care providers in your community? In this case, mental health care providers includes professional counselors, psychologists, psychiatrists, and social workers.
    a. Have these experiences affected the way you provide services to your congregation members. If so, how?
10. As a pastor, what is the most challenging part of providing mental health services to congregation members?

APPENDIX G

PILOT STUDY INTERVIEW QUESTIONS

1. I want to begin by learning a little bit more about you and your ministry. Tell me about your background pastoring in the Black Church.
    a. What are some of the highlights about your journey/call into ministry?
    b. I know that there are many spiritual rewards to being a pastor like seeing people receive Christ and I'm wondering what are 2-3 other parts about being a pastor that you find rewarding?
    c. Tell me about some of the training you have received to prepare you for your pastoral role.
2. Now that I feel I have gotten to know you as a pastor a little more, I would like to ask you a little bit about the church you pastor. Churches are different and have different ways of balancing the salvation message and social justice message. For example some churches are primarily one or the other while others may be a combination. I'm wondering how you would describe how you balance the two?
    a. If a combination of the two, what percentage would you assign to each?
3. I'm going to transition now and ask some more specific questions about providing support to congregation members. How do you see your role in attending to the mental health needs of members of your congregation? For example, how would you describe your role if a member approached you and stated that they were struggling with anxiety and/or depression?

4. I know that you often see people during some of the most difficult times in their life. How do you respond to a member who seeks your guidance during the following traumatic live events and stressors? With each of these, please describe your process in determining what services a congregation member may need.
    f. Anxiety/Depression
    g. Bereavement
    h. Parenting Issues
    i. Relationship Difficulty/Divorce
    j. Unemployment/Financial Concerns
5. I'm wondering as a pastor what is the most challenging part for you in attending to mental health concerns of your congregation members?
6. I want to ask you about how you think about anxiety and depression. There is a model that says issues like depression and anxiety are a combination of biological, psychological, social, and spiritual factors. What percentage of anxiety and depression do you attribute to biology, psychology, social, and spiritual factors ?
    a. Let's look at each of these factors separately. Do you think it is possible to over (or under) use any particular factor as a coping method. For example, it is possible to overly rely on (or neglect) on biological forms of coping, such as medication?
7. Could you provide an example of a time when a congregation member who had been struggling with an issue used religion as a support that helped them through this time? Can you give me an example of a time when you saw someone use their religion in a way that ultimately did not help them?

8. What are some of your positive and negative experiences with mental health care providers in your community? In this case, mental health care providers include professional counselors, psychologists, psychiatrists, and social workers. Have these experiences affected the way you provide services to your congregation members. In other words, would you refer a member to a mental health provider? Why or Why not?
9. This last question is a bit more personal but I want to remind you about anonymity as your name will not be attached to your interview questions. Based on statistics and from conversations I have had with pastors, it appears that pastors and their families are at an increased risk for experiencing feelings of anxiety and/or depression? Have you or someone close to you ever struggled with these feelings of anxiety and/or depression. This does not mean that you had to receive a formal diagnosis. Please be as specific as possible, but feel free to share only as much as you feel comfortable.

APPENDIX H

RESEARCH TEAM RECRUITMENT EMAIL

Email to Dr. Shelly Brown-Jeffy:

Hi Dr. Shelly,

I hope that you are enjoying your summer and that you are getting some much deserved R & R :) I wanted to check in with you about dissertation stuff. I am at the point now of forming my research team for the study. Since I am doing Consensual Qualitative Research I need a team of at least 3 to help review the interviews and analyze the data. I will be on the team and Dr. Cashwell has also agreed. Since I value your input so much and you bring the Sociology perspective I was wondering if you would be willing to be a part of the team as well. I can send you any additional information you may need. I know one of the biggest questions people normally have is about time commitments and your schedule is already jam packed. During the analysis stage we will have to meet and you would have to review the transcripts. I also hope to have an initial meeting soon to get the ball rolling since I want to propose during the Fall semester. Please let me know what you think.

I so appreciate you and all that you do!

Email to Dr. Metoka Smith:

Hi Metoka. I hope all is well with you! I wanted to know if you would be willing to do me a favor. I am in the process of writing my Chapter 3 and have come to the part where I need to describe the auditor...and you were the first person that came to my mind because of your familiarity with the subject of the Black Church as well as the CQR process. So I guess I'm asking if you would be willing to serve as auditor when that time comes. Please feel free to let me know if you need more information or if you have more questions. Thanks so much and I look forward to hearing from you soon.

Janeé

APPENDIX I

FULL STUDY INTERVIEW QUESTIONS

1. I want to begin by learning a little bit more about you and your ministry. Tell me about your background pastoring in the Black Church.
   a. What are some of the highlights about your journey/call into ministry?
   b. I know that there are many spiritual rewards to being a pastor like seeing people receive Christ and I'm wondering what are 2-3 other parts about being a pastor that you find rewarding?
   c. Tell me about some of the training you have received to prepare you for your pastoral role.

2. Now that I feel I have gotten to know you as a pastor a little more, I would like to ask you a little bit about the church you pastor. Churches are different and have different ways of balancing the salvation message and social justice message. For example some churches are primarily one or the other while others may be a combination. I'm wondering how you would describe how you balance the two?
   a. If a combination of the two, what percentage would you assign to each?

3. How often do you see individual congregation members facing issues such as anxiety, depression, relationship issues, bereavement, and unemployment?
   a. What other mental health issues do you see?

4. I know that you often see people during some of the most difficult times in their life. How do you respond to a member who seeks your guidance during the following traumatic live events and stressors? With each of these, please describe your process in determining what services a congregation member may need. Please provide a specific example of each.
   a. Anxiety/Depression
   b. Bereavement
   c. Parenting Issues
   d. Relationship Difficulty/Divorce
   e. Unemployment/Financial Concerns

5. I'm wondering as a pastor what is the most challenging part for you in attending to mental health concerns of your congregation members?

6. I want to ask you about how you think about anxiety and depression. There is a model that says issues like depression and anxiety are a combination of biological, psychological, social, and spiritual factors. What percentage of anxiety and depression do you attribute to biology, psychology, social, and spiritual factors ?

a. Let's look at each of these factors separately. Do you think it is possible to over (or under) use any particular factor as a coping method. For example, it is possible to overly rely on (or neglect) on biological forms of coping, such as medication?

   Follow up: What about psychological, social, spiritual?

7. Could you provide an example of a time when a congregation member who had been struggling with an issue used religion as a support that helped them through this time? Can you give me an example of a time when you saw someone use their religion in a way that ultimately did not help them?

   Follow up: Some of the issues could be related to relationship problems, unemployment, bereavement, anxiety, depression, or parenting concerns.
   Follow up: What particular parts of their religion either hurt or helped them through their struggle?

8. What are some of your positive and negative experiences with mental health care providers in your community? In this case, mental health care providers include professional counselors, psychologists, psychiatrists, and social workers. Have these experiences affected the way you provide services to your congregation members. In other words, would you refer a member to a mental health provider? Why or Why not?

9. This last question is a bit more personal but I want to remind you about anonymity as your name will not be attached to your interview questions. Based on statistics and from conversations I have had with pastors, it appears that pastors and their families are at an increased risk for experiencing feelings of anxiety and/or depression. Have you or someone close to you ever struggled with these feelings of anxiety and/or depression. This does not mean that you had to receive a formal diagnosis. Please be as specific as possible, but feel free to share only as much as you feel comfortable.

   Follow up: How were you/and or your loved one(s) able to cope through this time?

   Follow up: How does your personal experience with these struggles inform how you respond as a pastor?

APPENDIX J

INSTITUTIONAL REVIEW BOARD APPROVAL

To: Craig Cashwell

From: UNCG IRB

Date: 8/30/2012

RE: Notice of IRB Exemption
Exemption Category: 2.Survey, interview, public observation
Study #: 12-0294
Study Title: What Then Shall We Say to These Things? An Investigation of Pastoral Response to Mental Health Needs in the Black Church

This submission has been reviewed by the above IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

Study Description:

The purpose of this project is to investigate pastors' responses to parishioners dealing with anxiety and depression and the level and type of support offered.

Investigator's Responsibilities

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. The IRB will maintain records for this study for three years from the date of the original determination of exempt status.

CC:
Shelly Brown-Jeffy, Sociology
Janee Avent
ORC, (ORC), Non-IRB Review Contact

APPENDIX K

SUMMARY OF BRACKETING EXERCISE: RESEARCH TEAM

Prior to beginning the data collection, each member of the research team and the auditor completed a bracketing exercise. Each member completed this exercise independently and then met as a collective group to discuss. The auditor was not present for this meeting but themes from her bracketing document were discussed with the team. Each member discussed biases, expectation, history with the church, familiarity with the CQR procedure, racial dynamics, and any other reflections that may have influenced the process. Each of the research team members as well as the auditor attended the Baptist church when during their childhood. Characteristics, biases, and expectations of the research team are listed below:

- Each of the research team members identify as a part of academia.
- Two of the research team members and the auditor identify as African American females and have significant familiarity with the Black Church.
- The members of the research team view counseling as a beneficial process.
- The student researcher was the only student on the team.
- The members of the research team value the integration of spirituality and counseling.